Mental Health Practitioners’ Understanding of Informed Consent with Adolescents

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by

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare to satisfy the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

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The purpose of this study was to understand the impact of informed consent on the delivery of psychiatric services to adolescents and the way in which mental health practitioners understand and address informed consent in their treatment of adolescents. A key focus of this study examined how informed consent influenced adolescent mental health utilization and retention.

The study sought to explore the following questions: (1) How do practitioners understand adolescent informed consent? (2) How does informed consent affect adolescent access to mental health treatment and utilization as perceived by practitioners? (3) How do practitioners understand and describe the impact informed consent has on adolescent engagement in mental health treatment? (4) How do practitioners experience the ramifications of informed consent in building a therapeutic relationship with adolescents?

This qualitative study utilized an interpretive phenomenological research design. Twenty mental health practitioners with a median age range of 36-45 participated in semi-structured interviews aimed at understanding the importance of informed consent with adolescents. Through the use of this research method, their experiences were captured through semi-structured interviews to gain a deeper understanding of informed consent as a phenomenon. As the interpretations of their experiences emerged, these were summarized as exemplars. Consequently, the themes stemmed from the exemplars, and practitioners revealed their knowledge and experiences with practice patterns in mental health clinics that affected how mental health care was provided to adolescents. The practitioners were Licensed
Master Social Workers or Licensed Clinical Social Workers who had clinical experience in mental health settings and the psychosocial treatment of adolescents.

The findings of this dissertation study suggest that practitioners generally follow New York State Office of Mental Health guidelines for practice, which are interpreted by clinics, in order to render mental health treatment to adolescents. Practitioners reported that taking active roles with adolescents cultivate and facilitate adolescent engagement and utilization of mental health care. Issues of confidentiality and the ethical right of adolescent self-determination emerged as practitioners examined or discussed parental involvement in their treatment of minors. These themes were interconnected with the dynamics of clinical care as practitioners described trust as important in establishing therapeutic alliances in implementing an adolescent-centered approach aimed at improving treatment adherence. Implications of this study’s findings for clinical practice, service delivery and future research were discussed.
ACKNOWLEDGEMENTS

The focus of this dissertation was aimed at examining mental health practitioner’s understanding of informed consent with adolescents in clinical settings. This dissertation study explored the impact that informed consent had on the delivery of adolescent mental health care and utilization and on the formation of the therapeutic alliance between adolescents and practitioners. It was through the experiences of the practitioners that I was able to fully grasp and comprehend the challenges they face when working with adolescents in various mental health clinics. Their candidness, transparency and courage enabled me to capture the essence of their experiences while gaining an in-depth understanding of their daily roles. I thank all of them for teaching me the importance of building and cultivating a therapeutic alliance with adolescents while advocating for their voices to be heard.

I would like to thank the members of my dissertation committee for their guidance, wisdom and encouragement. To Dr. Manny J. González, my committee chair, I thank you for your spiritual support and insight. You have strengthened and inspired me to think more critically and assisted me to emerge as a confident scholar. To my amazing Dean and committee member, Dr. Mary M. Cavanaugh, whose unwavering involvement and investment in my study imparted knowledge and skills, my thank you. Finally, I would like to thank Dr. Rodney Watts, for your contribution to this study. Your presence and intelligence were always felt during the writing of this dissertation.

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Most of all, I would like thank my sovereign God for constantly renewing my strength and enabling me to stand on heights. He always has a plan to prosper us, plans to give us a hope and a future.

To those who read this dissertation may you find encouragement as you forge ahead in your future endeavors.

Rudyard Kipling’s Poem entitled “If,” inspires faith and hope that we can emerge confident and triumphant in the face of adversity.

If you can keep your head when all about you are losing theirs and blaming it on you,
If you can trust yourself when all men doubt you,
But make allowance for their doubting too;
If you can wait and not be tired by waiting,
Or being lied about, don’t deal in lies,
Or being hated, don’t give way to hating,
And yet don’t look too good, nor talk too wise:

If you can dream—and not make dreams your master;
If you can think—and not make thoughts your aim;
If you can meet with Triumph and Disaster
And treat those two impostors just the same;
If you can hear the truth you’ve spoken
Twisted by knaves to make a trap for fools,
Or watch the things you gave your life to, broken,
And stoop and build 'em up with worn-out tools:

If you can make one heap of all your winnings
And risk it on one turn of pitch-and-toss,
And lose, and start again at your beginnings
And never breathe a word about your loss;
If you can force your heart and nerve and sinew
To serve your turn long after they are gone,
And so hold on when there is nothing in you
Except the Will which says to them: 'Hold on!'

If you can talk with crowds and keep your virtue,
Or walk with Kings—nor lose the common touch,
If neither foes nor loving friends can hurt you,
If all men and women count with you, but none too much;
If you can fill the unforgiving minute
With sixty seconds' worth of distance run,
Yours is the Earth and everything that's in it,
And—which is more—you'll be a Man or Woman, my child!
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Chapter I: Problem and Justification

Introduction

The Surgeon General’s report on mental health (U.S. Public Health Service, 2000) revealed that an estimated 21% of children and adolescents suffer from mental health disorders (ranging from depression and anxiety to Attention Deficit Hyperactivity Disorder and conduct disorders) of which approximately 11% are severe. In addition, a high incidence of developmental disorders exists among children with emotional and behavioral problems (Jacobstein, Stark, & Laygo, 2007). For children, co-occurring mental health disorders often go undetected, and they enter into the child welfare system or are involved with the juvenile justice system rather than receive mental health treatment. This is especially true for children from poor ethnic families (Jacobstein et al., 2007). Approximately 47% of children in the child welfare system between the ages of 2 and 14 have emotional and substance abuse disorders, and 45% of children in the juvenile justice system meet the criteria for mental health disorders (Stroul & Blau, 2008). While there are evidence-based services that are available for children and adolescents to address their mental health needs, in order to implement research-informed practices and interventions, it is important to understand which treatments work most effectively. Therefore, it is crucial to assess needs, identify gaps, and assess provider and community capacities for the implementation of effective programs to fit the needs of children and adolescents. The chosen interventions should align with the values and principles that fit the cultural and linguistic needs of the families involved (Stroul & Blau, 2008).

The development of effective mental health community-based services for children and adolescents has received increased attention over the last two decades (Holden, Friedman, & Santiago, 2001). Increased rates of childhood mental health disorders—coupled with a lack of
access and the underdevelopment of appropriate services—have furthered the need to understand and address these crucial issues. According to Stroul and Blau (2008), most children in need did not receive adequate mental health services; instead, children received treatment in restrictive settings where services were limited to outpatient, inpatient, and residential treatment with few community-based options. Escalating mental health costs have magnified the importance of developing integrated services within these communities for children and adolescents. Regrettably, less than half of children with mental health disorders actually receive any kind of treatment to address their needs (Power, 2003).

**Barriers to Mental Health Access and Treatment**

Barriers to mental health services complicate treatment for children and adolescents. These include problems with access and eligibility, fragmented service delivery, and inflexible financing (U.S. Department of Health and Human Services Office on Disability, 2005). Additional psychosocial barriers include cultural factors associated with parent-child relationships, racial and ethnic group membership, and provider-client dynamics. Parent and client perceptions of mental health treatment also create barriers to access for children and adolescents (Power, 2003).

Adolescent mental health disorders are often overlooked or misdiagnosed, which leads to inadequate or inappropriate care (Power, 2003). Inadequate screening and a lack of comprehensive interdisciplinary assessment in schools and other settings are major causes of this failure to understand children’s complex needs. In addition, funding streams are category based and eligibility for these funds is often restrictive. Not only are parents frustrated, but their children’s care can be fragmented or inadequate; this fragmented service delivery seems to be the
norm, so much so that families find it difficult to access and maintain care, and mental health agencies do not communicate with other organizations that serve children, such as schools (Jacobstein et al., 2007; Wade, Mansour, Guo, Huentelman, Line, & Kelleret, 2008). Although continuity of care is particularly important for children and adolescents with complex needs, it can be difficult to achieve. Many programs are organized by age, but eligibility systems are not aligned within these systems. If adolescents drop out of school, they may find it difficult to obtain services until they are able to access the adult system. This fragmentation produces gaps in essential community services. Family programs such as respite care, crisis behavioral supports, home-based behavior intervention, and after school care are generally not available to support family caregivers (Bai, Wells, & Hillemeier, 2009; Vostanis, 2007). Therefore, improving the effectiveness of mental health services and making them more accessible in communities are vital steps (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003; Sarvet & Wegner, 2010; Weisz, Sandler, Durlak, & Anton, 2005).

Adolescents from poor socioeconomic backgrounds and those of racial and ethnic minority status are less likely to receive mental health care than White children from the upper and middle classes. Furthermore, minority adolescents with mental health disorders generally have higher levels of functional impairment in social and occupational spheres than White adolescents with similar disorders; these disparities may be due to the challenges associated with poverty, discrimination, and language barriers (Inkelas, Raghavan, Larson, Kuo, & Ortega, 2007; Power, 2003). Adolescents facing poverty are also likely to have fewer resources from which to draw and limited access to mental health services (Stern, Smith, & Jang, 1999).

In addition, the quality of adolescent care is often insufficient to produce successful outcomes (Stevens, Kelleher, Ward-Estes, & Hayes, 2006). Interventions may not be responsive
to the cultural values and needs of children and their families, and parental perceptions of relationships between providers further contribute to service disruptions for children (Stevens et al., 2006). Lack of parental knowledge of the child’s problems or different views of mental disorders make obtaining services difficult: parents or primary caregivers may overlook emotional disturbances, fearing stigmatization and the possible rejection of their child, which may also interfere with obtaining mental health services (Wisdom, Clarke, & Green, 2006). Conversely, some parents may prefer to obtain information regarding the adolescent’s mental health treatment, which may also deter the young person from seeking services (Tan, Passerini, & Stewart, 2007).

To date, there has been limited research examining practitioners’ understanding of adolescent informed consent and the resultant impact on adolescent access to psychiatric services (Beeman & Scott, 1991; Kaser-Boyd, Adelman, & Taylor, 1985; Munson, Floersch & Townsend, 2009; Taylor, Adelman, & Kaser-Boyd, 1985a). The fundamental issue with consent for minors is the question of decision making among those who are not fully competent to decide for themselves. Consent and confidentiality are important issues in clinical work with adolescents. These issues often arise in the course of treatment, and the increasing emphasis on autonomy and consent for legal minors can lead to anxiety among professionals who have to struggle with these dilemmas. Professionals wish to respect this autonomy and the decisions of parents or guardians and adolescents; at the same time, they also have a duty to act in the best interests of these minors (Kuther, 2003; Tan et al., 2007). However, consent issues are particularly difficult with adolescents because their best interests are hard to define and are often subjective (Kuther, 2003). There is debate as to whether adolescents are mature enough to make decisions regarding their physical and mental well-being. Informed consent in mental health
poses particular challenges due to the fact that mental illness can determine whether a young person will be able to understand and determine the benefits and outcomes of treatment (Schachter, Kleinman, & Harvey, 2005).

To complicate matters further, determining an adolescent’s competence to receive mental health services often creates barriers to utilization and retention (Campbell, 2006). As a result, some practitioners prefer joint consent between parents and adolescents (Halasz, 1996). Additionally, parents often emphasize discussion of confidentiality and mental health benefits; in this sense, clinicians and parents indicate similar consent priorities (Jensen, McNamara, & Gustafson, 1991). Moreover, most states in the United States have traditionally considered adolescents incompetent to make decisions about their own medical treatment (Bello, 2010). Therefore, parents or legal guardians are often responsible for making decisions on the adolescent’s behalf. However, many adolescents are fully capable of making decisions and rendering consent concerning their mental health treatment, thus enabling access and retention (Jivanjee, Kruzich, & Gordon, 2009). According to Weithorn and Campbell (1982) and Tan et al. (2007), adolescents are capable of making decisions by the age of 9, and by the age of 14 they are fully capable of making complex decisions.

In New York State, a minor (defined as anyone under age 18) can obtain reproductive health services—including birth control, emergency contraception, abortions, treatment for STIs, HIV/AIDS, pregnancy care, rape crisis health services, and emergency care—without parental consent. A minor seeking mental health services can access treatment, including medication, without parental consent if any of the following conditions apply: the parent or guardian is not available; the provider determines that parental involvement would be detrimental to the course of treatment; or the parent or guardian has refused to give consent and a physician determines
that treatment is necessary and in the best interests of the minor. If none of these circumstances apply, New York law requires the consent of a parent or guardian for outpatient mental health treatment (Feierman, Leiberman, Schissel, Diller, Kim, & Chu, 2002; Roberson, 2007). Additionally, a minor 16 years of age or older who consents may be administered psychotropic medications without the consent of a parent or guardian or the authorization of a court when certain conditions apply.

In light of these varying legal stipulations, many mental health practitioners remain unclear about the ability of adolescents to offer informed consent for treatment. In fact, many programs in New York State urge practitioners to obtain parental consent to render psychiatric services to adolescents regardless of mental health laws. This practice can be attributed to legal, policy, and ethical issues involving capacity and confidentiality, all of which plays a role in who can consent to treatment. However, while adolescents remain under the legal auspices of their parents or guardians, they may believe that their privacy and confidentiality will be compromised. Consequently, these misperceptions may interfere with access and utilization. In outpatient clinical settings, most adolescents fail to complete treatment and some express a lack of support from their guardians because of misinformation regarding mental illnesses.

**Purpose of the Study**

The purpose of this study was to understand the impact of informed consent on the delivery of psychiatric services to adolescents and the way in which mental health practitioners understand and address informed consent in their treatment of adolescents. A key focus of this study examined how informed consent influenced adolescent mental health utilization and retention (Jacobstein et al., 2007).
The study sought to explore the following questions: (1) How do practitioners understand adolescent informed consent? (2) How does informed consent affect adolescent access to mental health treatment and utilization as perceived by practitioners? (3) How do practitioners understand and describe the impact informed consent has on adolescent engagement in mental health treatment? (4) How do practitioners experience the ramifications of informed consent in building a therapeutic relationship with adolescents?

**Conceptual Framework**

**The Historical Background of Informed Consent**

The practice of obtaining informed consent has its history and roots in medicine and biomedical research. The term informed consent emerged in the 1950s, and by the 1970s there was a shift from the physician’s obligation to obtain consent towards an emphasis on the quality of a patient’s understanding of information and his or her right to authorize or refuse medical intervention (Beauchamp, 2011). The early writings about informed consent are found in the Hippocratic writings and in Thomas Percival’s *Medical Ethics* of 1803 (Dolgin, 2010). These writings suggest that the practice of informed consent was imposed on medicine from without and that physicians’ ethics traditionally favored non-disclosure. There was no concern with or appreciation of the patient’s right to consent or to be informed about the medical intervention; instead, informed consent was imposed upon the medical profession by judges and government officials. During the 1950s and 1960s, consent for surgical practices evolved, resulting in a duty to inform patients about the specific nature of these procedures. Hence, the word “informed” was added to consent (Beauchamp, 2011).

In a landmark case, Salgo v. Leland Stanford Jr. University Board of Trustees (1957), the court ruled that it is the duty of practitioners to disclose risks and alternatives to treatment and
further argued that there is a duty to disclose the nature and consequences of the medical treatment and to ensure that the patient is adequately informed (Berry, 2005). Three landmark cases from the 1970s had a further impact on informed consent, arguing that informed consent can only be practiced if the patient has sufficient information to make an informed decision (Dolgin, 2010). According to Beauchamp (2011), the 1970s decisions were tied to increasing social concerns that propelled the growing field of bioethics and hence concerns about the ethical value of informed consent practices. However, legal changes concerning the ethical value of informed consent provide little information on how informed consent was actually experienced by patients. A national survey conducted by Harris and Associates for the U.S. President’s Commission on Bioethics in 1982 concluded that 85% of practitioners obtained consent from their patients before surgery; however, it was the physician and not the patient who often made the ultimate decisions regarding treatment (Beauchamp, 2011).

Although the concept of informed consent has its origins in medicine and health care, it has been applied legislatively, judicially, and administratively to a wide range of other client groups in other fields, including mental health (Miller & Wertheimer, 2010). This widespread application of informed consent has caused a shift in the relationships between providers and patients, a transformation of past historical doctrines regarding consent into a dynamic process between provider and patients that requires competence and autonomous authorization in order to make informed decisions (Miller & Wertheimer, 2010).

**Ethical Considerations**

What makes informed consent complicated is that it is supposed to be self-determined by the individual according to the institutional or organizational rules of consent (Beauchamp, 2011;
Miller & Wertheimer, 2010). Ethical issues for informed consent state that in order to be true informed consent, it must be autonomous; therefore, an organization’s policies should be specifically fashioned to maintain patient self-determination (Faden & Beauchamp, 1986). This approach centers attention on the need for effective communication and genuine understanding on the part of patients. Without a proper climate of exchange in the consent context, a request for informed consent by a practitioner may be met with a desired result for the practitioner rather than the patient.

How can social workers in mental-health settings secure adequate informed consent from adolescents, one that supports self-determination? Informed consent needs to be secured in a way that will not cause stigma or harm the young person’s dignity, will not violate privacy and confidentiality, and will not lead to discriminatory treatment (Congress, 1996; Reamer, 1987). In addition, the process of informed consent should protect the client’s right to treatment or non-treatment. As part of this process, social workers must be sensitive to clients’ cultural and ethnic differences related to the meaning of such concepts as self-determination, autonomy, and consent (Dolgoff, Lowenberg, & Harrington, 2005; Reamer, 1987). Social workers should also fulfill their ethical obligations to engage clients as genuinely as possible as partners in the informed-consent process.

In procuring informed consent, ethical dilemmas arise, especially due to the social worker’s obligation to obey the laws, rules, and regulations of various agencies and state organizations (Reamer, 2001; Rhodes, 1986). If the agency’s goals conflict with the client’s interests, the practitioner must decide what to do (Rhodes, 1986). For example, if an agency’s policy is to obtain parental consent before engaging adolescents in mental health treatment, what should the practitioner do when such consent is not in the adolescent’s best interests? What
assumptions should the practitioner make? Other ethical dilemmas may arise out of obligation to state or federal laws; for example, in New York State, minors under the age of 16 cannot self-consent for mental health treatment (Consent for Mental Health Treatment of Minors, 2015). At the same time, social workers also feel an obligation to uphold the autonomy and wishes of the clients they serve. Therefore, mental health practitioners need to understand which questions in the informed-consent dialogue are important to address. Engaging clients in this process can also foster improved understanding for both a process and outcome.

In addition, practitioners and clients may have their own values that conflict with those of the agency, the client, other colleagues, the social work profession, or society itself. Personal values usually develop out of familial, cultural, and societal values, and they influence our decisions in serious and profound ways (Congress, 1996; Reamer, 2006). For practitioners engaging clients in mental health treatment, key ethical questions include the following: What are the goals for treatment? What are the practitioner’s responsibilities? What are the client’s reasons for treatment? What are the values of the agency? What are the ethical assumptions of the profession? The answers to these questions may become complicated when the personal values of the practitioner do not align with others involved in the process, including the clients themselves.

Concerning informed consent, there may be policies that shape its nature in the agency and determine the role of the social worker. This, however, may be contrary to the social worker’s value base (Reamer, 1987). Rhodes (1986) argued that social workers must ask what perspectives, beliefs, or guidelines help them evaluate and justify their decisions concerning ethical dilemmas. In order to determine if an adolescent can provide informed consent for mental health treatment, ethical practice requires that the social worker assess an individual’s
capacity and competence and place the individual’s right to self-determination above the social worker’s or agency’s self-interest. This determination will also require that the social worker consider the adolescent’s rights and privileges of informed consent, which are subject to societal values and which affect decisions made by practitioners. All of these ethical dilemmas require social workers to determine which issues are ultimately resolvable and which are not, based on their own values and ethics.

Due to the complexity of these social work decisions, the Code of Ethics published by the National Association of Social Workers (NASW) (1996) provides systematic guidelines for resolving ethical issues. The Code of Ethics is intended to serve as a guide and as a basis for the adjudication of issues in ethics. In addition, the NASW Code of Ethics delineates certain values as key to social work and describes some ethical principles based on these values. The first value includes service, and the ethical principle is to help people in need and to address social problems. The second value addresses social justice, and the corresponding ethical principle calls for social workers to challenge social injustice. The third value underscores upholding the dignity and worth of the person, and its ethical principle includes respect for the dignity and worth of the person. The fourth value upholds the importance of human relationships, and the ethical principle for social workers is to recognize this importance. Integrity is the fifth value, and it calls for social workers to behave ethically and in a trustworthy manner. Lastly, competence is the sixth value, and the resultant ethical principle requires that social workers practice within their area of competence and develop the appropriate professional expertise (Congress, 1996; NASW, 1996; Reamer, 2006).

Mental health practitioners have different ways of solving ethical dilemmas but share similar professional values (Congress, 1996). The question specific to this dissertation study is
about whose dignity and worth will ultimately be promoted, the parent’s or the adolescent’s? For example, a parent seeks mental health services for an adolescent, but the adolescent refuses treatment because he or she is concerned about confidentiality: How should the practitioner proceed? According to Reamer (2000), social workers are guided by two principles: (a) beneficence, a positive obligation to provide good and (b) non-malfeasance, a negative obligation to cause no harm. Social workers acting out of beneficence may be inclined to agree with the adolescent in order to protect his or her confidentiality; however, competing personal, societal, or agency-related values may steer the social worker to decide on parental consent for the adolescent. Many social workers do not use a philosophical approach at all but instead base their decisions on their practice experience or on the Code of Ethics (Congress, 1996).

**Ethical Models of Informed Consent**

There are several models or approaches to ethical decision making regarding informed consent. The following descriptions will outline the ETHIC model (Congress, 1996), the normative ethics system approach (Reamer, 2006), and the humanistic and situational ethics model (Dolgoff et al., 2005; Harrington & Dolgoff, 2008). These models may help mental health practitioners make better practice decisions regarding adolescent informed consent.

**The ETHIC model**

The ETHIC model developed by Congress (1996) includes five steps: Examine, Think, Hypothesize, Identify, and Consult. First, in order to assess how their personal values affect the decision to ensure the adolescent’s self-determination in mental health treatment, social workers must examine their own values as well as the relevant values of the society, the agency, the client, and the profession (Congress, 1996). For example, some social workers might feel that
parents should be involved in the mental health treatment of the adolescents and that confidentiality is non-negotiable between parents and adolescents. However, agency policies may reflect a different set of values concerning a minor’s consent for mental health treatment, something that might subsequently become a concern for the social worker making decisions about the adolescent’s mental health treatment.

Next, social workers must think about which NASW Code of Ethics standards might apply concerning confidentiality and self-determination (Congress, 1996). The NASW (1996) Code of Ethics supports confidentiality and autonomy, which in turn supports the social work value of self-determination. Autonomy means to be free from interference by others and from limitations (such as inadequate understanding) that may prevent adolescents from making sound decisions regarding their treatment. In addition, social workers can assess when disclosure is necessary to prevent serious, foreseeable and imminent, harm to the adolescent or others.

Social workers can also hypothesize about different courses of action and possible consequences. According to Congress (1996), the social worker should think about different scenarios and endings in order to resolve ethical dilemmas. In the case of adolescent self-determination to supply informed consent for mental health treatment, the social worker can determine if the adolescent has the capacity to consent to his or her own treatment: Does the adolescent understand the risks and benefits of mental health treatment? What would be the professional consequences for the practitioner if the adolescent refused to involve his or her parents in mental health treatment? If the therapist decided not to involve the parents based on his or her personal values and those of the adolescent, how would the parents’ trust in the practitioner be affected or vice versa? Would the adolescent be forced to leave treatment or
would the adolescent ultimately decline treatment? These are only some of the questions that social workers must consider when making ethical decisions.

In addition, in view of social work’s commitment to the most vulnerable members of society, the social worker will need to identify who will benefit and/or who will be harmed by these decisions (Congress, 1996). Adolescents with mental health disorders are considered to be particularly vulnerable; therefore, social workers are obligated to act in their best interests above all others (Power, 2003; Stroul & Blau, 2008). The social worker bears the responsibility of making decisions that will protect the interests of the adolescent even if doing so requires that the practitioner disclose without consent. For example, if there is a matter of risk or harm to the adolescent, then the social worker is responsible for acting on his or her behalf no matter the consequences.

Finally, the social worker must consult with a supervisor or colleagues, which raises the question of whether the social worker can maintain confidentiality and still share information with others (Congress, 1996). It is impossible for social workers to maintain full confidentiality with their clients. For example, in the case of informed consent, social workers will need to consult with a supervisor to ensure that the adolescent has the full capacity to offer informed consent and that the adolescent understands the nature of the mental health services in question. In addition, social workers will often have to advise adolescents that in matters of danger or harm to themselves or others, the social worker has a duty to inform immediate family members and protect the adolescent from danger. In this case, consultation with a supervisor will help make the appropriate course of action clear.
Reamer’s Normative Ethics System Approach

In contrast to Congress’ ETHIC model (1996), Reamer’s normative ethics system approach (2006) is predicated on deontological and teleological theories. Deontological theories are those that claim that certain actions are inherently right or wrong, good or bad, without regard for their consequences (Reamer, 2006). Deontologists hold rules, rights, and principles to be sacred and inviolable, and they focus on fulfilling one’s duties, respecting the autonomy of others, and treating people with equal justice (Osmo & Landau, 2006). For example, a social worker who practices from a deontological perspective will argue that the profession has an inherent obligation to respect an adolescent’s right to self-determination so long as the actions involved are voluntary and informed; for these practitioners, the social worker can become involved even if the adolescent may not have the capacity to understand the risks and benefits of mental health treatment.

Teleological theories weigh the potential consequences of decisions (Reamer, 2006). From this perspective, the social worker anticipates the outcomes of various courses of action and weighs the costs and benefits involved in those decisions. For example, what are the costs and benefits involved in respecting an adolescent’s right to confidentiality in mental health treatment? There are two major teleological schools of thought: egoism and utilitarianism (Osmo & Landau, 2006; Reamer, 2006). Egoism is a form of teleology that focuses on maximizing one’s own good and self-interest. By contrast, utilitarianism (which holds that an action is right if it promotes the maximum good) is by far the most popular theory and has served as a framework for many decisions made by social workers (Reamer, 2006). When faced with conflicting duties, social workers should do that which will produce the greatest benefit and good. Social workers who practices from a utilitarian approach will respect an adolescent’s right
to self-determination and confidentiality in support of the adolescent’s right to informed consent in mental health treatment, bringing about the greatest good for him or her.

The problem with utilitarianism is that this framework can sometimes be used to justify competing options. Additionally, the rightness or wrongness of an act is determined solely by whether the social worker believes the act to be good or bad (Palmer, 1999). For example, a utilitarian social worker who supports an adolescent’s consent to mental health treatment may decide not to engage or involve the parents, regardless of the consequences, in order to protect the adolescent’s confidentiality, resulting in what the social worker believes is the greatest good for the adolescent. However, another social worker practicing utilitarianism may weigh in differently and might argue that some disclosure to the adolescent’s parent outweighs the adolescent’s right to confidentiality if it means protecting the adolescent from certain risks—which is, for that social worker, the greatest good.

Palmer (1999) and Reamer (2006) also distinguish between act and rule utilitarianism. According to act utilitarianism, the rightness of an action is determined by the goodness of the consequences produced in an individual case or by that particular act. By contrast, rule utilitarianism takes into account the long-term consequences likely to result if one generalizes from the case at hand or treats it as a precedent. For example, a rule utilitarian might argue that the precedent established by an adolescent’s breach of confidentiality to a parent would generate more harm than good, regardless of the benefits to protect the adolescent in this one particular case. The social worker who practices rule utilitarianism might argue that the resulting precedent might undermine other adolescents’ trust in social workers, particularly if their confidentiality and self-determination for mental health treatment are at issue, thus limiting social work’s effectiveness as a profession.
Reamer (2006) notes that a key problem with utilitarianism is that different practitioners are likely to consider different factors and weigh them differently as a result of their different values, life experiences, and political ideologies. In addition, when the philosophy is taken to extremes, some social workers who practice from a utilitarianism perspective can justify trampling on the needs of the minority in order to benefit the majority, a result contrary to social work practice in general. In addition, some people’s motivations may be incongruent with their actions and the rationales for their choices (Riley, 2009). In principle, a social worker could argue that policies regarding adolescent informed consent do not outweigh the parents’ right to be involved in their child’s mental health treatment; as a result, he or she might violate the values of confidentiality, autonomy, and self-determination.

**Humanistic and Situational Ethics Approach**

Dolgoff et al. (2005) and Harrington and Dolgoff (2008) offered further perspectives for making ethical decisions and solving ethical dilemmas, including humanistic ethics and situational ethics. Humanistic ethics combines a strong sense of idealism with opportunities for individual choice. An idealistic view of human nature that is essentially positive—together with an optimistic stance about the future—provides the basis for this approach. The focus is on causal rather than moralistic explanations of human behavior, and it stresses the capacity, opportunity, and responsibility of every person to make sensible choices. Providers who practice from this standpoint identify value priorities and feel that they can make ethical decisions about most practice problems that they may face. This approach is similar to the utilitarian model of ethical decision making (see Reamer 2006). More importantly, like the utilitarian approach, there is also an emphasis on individual responsibility for decisions (Dolgoff et al., 2005).
This practice approach however, may be problematic in that it focuses solely on the individual’s decisions, a stance that may further increase ethical dilemmas. Clients who seek social work support do not always require self-actualization as well (Dolgoff et al., 2005; Harrington & Dolgoff, 2008). For example, when an adolescent seeking mental health services consents to care and informs the clinician that he or she has been truant from school, should the practitioner provide mental health services that support the adolescent’s decision to be truant? The chief criticism of using this practice approach to the exclusion of all others is that the resulting decisions may clash with other persons and groups and that decisions that are based on self-actualization without boundaries or responsibility can lead to destructive actions (Reamer, 2006).

In contrast, situational ethics claims that there are no ethical laws and that ethical decisions should be influenced only by the normative value of love (Dolgoff et al., 2005). Social workers who practice from situational ethics evaluate the right thing to do in every situation and try to choose a course of action that demonstrates the most love for all those concerned. Situational ethics would allow practitioners to lie in order to save a life or prevent harm to others. Dolgoff et al. (2005) and Lyden (1998) agree the situational ethics approach was originally taught from a Christian perspective that focused on the principle that love justifies the means necessary to achieve its own ends. Social workers who practice from this perspective do not have fixed rules that help them make decisions or resolve ethical dilemmas. Inevitably, these social workers will need additional support and guidance in making ethical decisions because situational ethics alone cannot be the definitive source of their decision making.

Dolgoff et al. (2005), Harrington and Dolgoff (2008), and Reamer (2001) have all asserted that ethical decision making requires being alert to the impact of cultural, societal,
personal, and professional values in order to reduce conflicts and to assist social workers in making ethical decisions based on client needs and the maintenance of the practitioner’s professional integrity. These scholars concur that a person’s cultural experiences and background (including personal values) implicitly dictate that person’s ethical decision-making process. If these influences become overt and explicit, the consequences may be stereotypes and biases rather than professional values and ethics. Dolgoff et al. (2005), Harrington and Dolgoff (2008), and Reamer (2001) further argued that social workers derive their values from their families, communities, professions, religions, and other groups with which they are in contact and which may also influence ethical decisions with clients. For example, social workers who work with some immigrant populations may prioritize a group value over an individual value, even though the NASW Code of Ethics prioritizes self-determination. In addition, social workers should avoid stereotypes and generalizations based on the client’s cultural group values and be aware that client values will not necessarily reflect or agree with the social worker’s personal values.

Dolgoff et al. (2005) recommended that decisions be approached step by step using the Ethical Rules Screen (ERS) (figure 1) and the Ethical Principle Screen (EPS), which ranks principles from the most important to the least important. The EPS employs the following principles: (1) protection of life, (2) equality and inequality, (3) autonomy and freedom, (4) least harm, (5) quality of life, (6) privacy and confidentiality, and (7) truthfulness and full disclosure. The ERS (shown below) should always be used first, and if it does not prove satisfactory, then the social worker uses the EPS (Dolgoff et al., 2005). When using the EPS, if (1) more than one principle is relevant to the analysis of a set of practice options and (2) each of these principles leads to a different outcome, then the rank order suggested in the EPS should be used to make a
decision. For example, if both confidentiality and full disclosure apply to a case or ethical situation, the ethical principle of confidentiality should receive priority (Dolgoff et al., 2005).

Figure 2.1: Ethical Rules Screen

Informed consent is derived from principles that autonomy and individuals’ capacity to consent to their own care should be respected (Congress, 1996; Dolgoff et al., 2005; Harrington & Dolgoff, 2008; Reamer, 2001; Reamer, 2006). Informed consent involves the issues of competence, voluntariness, and disclosure of information (Beauchamp & Childress, 1994; Campbell, 2006). Problems involving one or all of these issues make for difficult ethical dilemmas in social work practice. Informed consent involves the principle that individuals fully understand what they are consenting to. In mental health, the individual renders permission to the practitioner by signing documents that explain the nature of treatment, the risks and benefits, the patient’s mental health rights and his or her rights, to confidentiality and privacy. Often clients sign this form under the impression that doing so is a condition for treatment (Wagner, Davis, & Handelsman, 1998). The challenge facing social workers is to develop forms that are easy to read and understand, especially for adolescents consenting to mental health services.
There are several conditions that govern whether or not informed consent can be considered valid. According to the NASW Code of Ethics (1996), the following principles apply:

Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients’ right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions. (1.03)

Adolescents can be sufficiently informed as to what will occur during the treatment, what the results of the intervention will be, and what will happen if consent for the intervention is not given (Bello, 2010; Dolgoff et al., 2005). The adolescent should have full knowledge about alternate treatment options and the associated risks and benefits. In addition, the adolescent’s confidentiality should also be protected; however, the social work practitioner may need to breach confidentiality by disclosing information if there is a risk to the adolescent or to another person. Under these circumstances, the social work practitioner may find the ethical decision models designed by Dolgoff et al. (2005) and Reamer (2006) helpful. In following the ethical decision models (ERS and EPS), the social work practitioner is advised to follow the ERS model and determine if the NASW’s principle of upholding client confidentiality will help the clinician make the appropriate ethical decision. Whenever a practitioner has to choose between the client’s right to privacy and the duty to warn or protect those in danger, Congress (1996), Dolgoff et al. (2005), and Reamer (2001) underscore that practitioners follow the guidelines of the EPS model, in which the first principle is to protect life.
Informed consent also presupposes that the person who gives consent is competent to do so (Bello, 2010; Crain, 2000; Dolgoff et al., 2005). Campbell (2006), Dolgoff et al. (2005), Schachter et al. (2005), and Tan et al. (2007) provided examples of persons who may not be competent to provide informed consent, including young children, people with dementia and other cognitive disorders like Alzheimer’s or mental retardation; and the seriously emotionally disturbed. In terms of consent, people exist along a continuum, ranging from those who are fully capable of consent to others who are not at all capable. This conceptualization of competence has many implications for social workers as they consider their professional ethics and their practice with adolescents. There is a paradox with adolescents seeking mental health services: practitioners may support their self-determination and autonomy but find that legal systems define these adolescents as minors who are limited in their decision-making capacity and authority (Bello, 2010). Social workers must often reassess the meaning and practice of client self-determination, especially with adolescents. What are the ethical considerations that should guide a social work practitioner who is convinced that the adolescent has the capacity and autonomy to consent for mental health treatment but is under the New York State legal age to do so? The ethical dilemma arises out of the conflict between applying professional knowledge regarding capacity, respecting the adolescent’s right to make decisions regarding his or her mental health treatment, and maintaining in the case of this dissertation study, New York State law concerning consent for the mental health treatment of minors. In such cases, the social worker is obligated to abide by the law regardless of professional values or the client's self-determination.

Ethical dilemmas can create additional ambiguity and uncertainty (Congress, 1996; Dolgoff et al., 2005; Reamer, 2001; Reamer, 2006). Ambiguities rise out of uncertainty
concerning values and goals, specific practice knowledge, and the consequences of the intervention. Social work practitioners must keep pace with agreed-upon standards regarding consent with minors (including minors who are considered emancipated) because such knowledge will help practitioners make better ethical decisions on behalf of their clients.

Relevance of the Study for Social Work Practice in Mental Health Care

The social work profession has played a key role in improving the accessibility and quality of mental health care, and it is the largest mental health discipline in the United States (Harkness, 2011; Proctor, 2004). Social workers are the largest group of mental health professionals, comprising about 60-70% of the mental health work force, and they provide the majority of the mental health services in most communities, more than both psychiatrists and psychologists (Harkness, 2011; Proctor, 2004). For the purpose of this study, the two categories of mental health practitioners are the Licensed Master Social Worker (LMSW) and the Licensed Clinical Social Worker (LCSW). The Licensed Master Social Worker must meet New York State educational and exam requirements in order to be granted the licensure. Licensed Master Social Workers provide psychotherapy to individuals, couples, families and psychotherapy in group context. In New York State, Licensed Master Social Workers practice under the supervision of a Licensed Clinical Social Worker, a licensed psychologist or, a psychiatrist. The Licensed Clinical Social Worker encompasses the scope of practice of Licensed Master Social Worker and in addition includes the psychotherapy privilege to diagnose and treat mental, emotional, behavioral, addictive, and developmental disorders. The psychotherapy privilege includes additional educational and exam requirements as deemed by the state. Additionally,
Licensed Clinical Social Workers are recognized as reimbursable by insurance plans in New York State (New York State Office of Professions, 2015).

The American Board of Examiners in Clinical Social Work (2008) argued that clinical social workers in the mental health field should apply an understanding of cultural, experiential, cognitive, and historical determinants of behavior to interventions and treatment modalities consistent with a client’s diagnosis. Due to the ability of social workers to diagnose and treat clients with mental illness, the profession is in a position to help recipients of psychiatric services reach their maximum functional ability. Social work—with its commitment to the individual and the social environment, its psychosocial knowledge base, its awareness and knowledge of the interaction between person and community, and its ethical code and value system—can play an important role in helping clients receive services that are both humane and of the highest quality (Aviram, 1997).

The social work profession holds the right to self-determination among its highest values. The NASW Code of Ethics (1993) states, “The social worker should make every effort to foster maximum self-determination on the part of clients” (p.6). In the world of social work, the constraints of time and limited funding are exacerbated by the demands of increasing caseloads. As a result, self-determination is frequently the first right to be violated in the name of expediency, protection, and cost containment. Freedberg (1989) noted that maintaining daily contact with clients creates an inherent dilemma concerning self-determination and that agencies and social workers need to monitor the services delivered—thus managing the clients. These constraints pose ethical dilemmas for social workers in rendering mental health services to clients while at the same time respecting self-determination within the bounds of informed consent.
Reamer (1987, 2000) observed that, informed consent includes program admission, service delivery, and the release of confidential information. Social workers are obligated to employ procedures that ensure that coercion and undue influence do not affect clients’ decision to consent. It is also important that social workers uphold clients’ self-determination to provide consent, and ensure that this consent for procedures or actions is valid, and inform clients of their right to refuse or withdraw from treatment. The right to informed consent demands that the provider or social work clinician inform the client of the benefits, risks, and alternatives of a particular treatment (Bello, 2010; Schmidt & Reppucci, 2002; Scott, Reppucci, & Woolard, 1995). To this end, social workers should make the commitment to employ consent practices that are based on self-determination. Too often, there is an inclination to focus on the legal rationale for obtaining a signed consent form (e.g., to prevent a hypothetical lawsuit) instead of realizing the moral good that arises when clients fully participate in the consent process (Manning & Gaul, 1997).

Social workers play a critical role in educating clients about informed consent. Therefore, informed consent depends upon clinicians educating and supporting the right of clients to participate fully in their own medical decision-making processes. In this litigious society, there is sometimes more of an emphasis on consent as a legal contract than as a mutual collaboration designed to establish self-determination. Therefore, informed consent calls for a partnership between social workers and clients, one based on mutual respect and an appreciation of both the client’s and the practitioner’s knowledge base. For example, in mental health practice, social workers can bring to the table medical and technical information about diagnoses and treatments while the clients can provide their own personal and subjective experiences with mental illness.
Chapter II: Literature Review

Adolescents have particular difficulty accessing the mental health system (Huang, Stroul, Friedman, Mrazek, Friesen, Pires & Mayberg, 2005). Barriers to psychiatric treatment for adolescents include the following: the costs of care; the restrictions of specialized mental health care; and psychosocial barriers, including cultural factors, parent-child relationships, and negative perceptions about mental health treatment. The lack of both adequate screening and comprehensive interdisciplinary assessments further complicates mental health access for children and adolescents (Huang et al., 2005). Many state laws require parental consent in order to render mental health services to minors in non-emergency situations, including those of New York State (Consent for Mental Health Treatment of Minors, 2015). Consequently, the need for parental consent for adolescents seeking mental health treatment may play an important role in the underutilization of mental health care and the high dropout rates for youths who begin treatment. Adolescents are under the auspices of their parents or legal guardians, and misconceptions regarding privacy often interfere with services and treatment. To date, little research has examined the impact of practitioner perception on informed-consent practices for adolescents in outpatient mental health settings (Beeman & Scott, 1991; Taylor & Adelman, 1989; Taylor et al., 1985).

The literature review is divided into two sections: (1) Barriers to Mental Health Access and Treatment for Adolescents and (2) Informed-Consent Capacity, Self-Determination, and Confidentiality. The first section includes a brief overview of the current landscape of adolescent mental health and a review of empirical studies that underscore the factors that impact adolescent mental health access and treatment utilization. The second section includes a review of definitions of informed consent for adolescents (including the related elements of capacity,
self-determination, and confidentiality); a review of empirical studies on how practitioners perceive informed consent based on legal, ethical, and clinical practice issues; and an examination of how these issues impact access and utilization. Throughout the review, concepts derived from the empirical literature—as well as any gaps or limitations within this literature—will be noted.

**Barriers to Mental Health Access and Treatment for Adolescents**

The availability and use of mental health services depend on how they are financed and how practitioners are reimbursed. Studies that have examined mental health care financing (Mark, Buck, Dilonardo, Coffey, & Chalk, 2003; Mark, Levit, Buck, Coffey, & Vandivort-Warren, 2007) have found an increase in Medicaid expenditures for mental health services. By utilizing numerous public data resources—including the National Health Expenditure Account and the Substance Abuse and Mental Health Services Administration—researchers have observed changes in payers and providers, raising new challenges for the maintenance of quality and access (Mark et al., 2003; Mark et al., 2007). Mechanic (2008) for instance, analyzed the mental health costs for the severely and persistently mentally ill and postulated that the availability of specialized services, like assertive community treatment, be carefully monitored and assessed. Other studies (see Alexandre, Dowling, Rely, Stephens, & Laris, 2008; Deck & Vander Ley, 2006) analyzed adolescent retention patterns and the relationship between cost and mental health utilization. Access to Medicaid is a significant predictor of adolescent mental health service use, and this method of payment has become an important policy tool for increasing access to psychiatric services (Fawcett & Karban, 2005). For this reason, the introduction of market principles into mental health service provision has caused considerable
unease within various community mental-health systems. However, despite an extensive body of research regarding the costs of mental health services, scant attention has been paid to how these costs affect adolescents and their access to mental health services and treatment.

Given the prevalence of mental health problems among adolescents, changes are needed to address service access for youths. First is the need to reduce the risk of mental health problems for adolescents, and second is the need to promote greater access to care. The U.S. Department of Health and Human Services Office on Disability (DHHSOD) (2005) oversees the implementation and coordination of disability programs, policies, and special initiatives for millions of people in America who suffer from a range of disabilities, including mental health disorders. This office deepens the partnership between federal, state, and community stakeholders by supporting plans and initiatives designed to reduce barriers that people with disabilities face. In a report generated by the DHHSOD (2005), the importance of matching appropriate treatments to populations that are diverse in age, gender, race, and culture as well as reducing barriers to treatment was significantly underscored. Although government agencies oversee services and make recommendations for treatment, barriers persist—particularly for children and adolescents, whose problems with access and engagement remain.

In the past, government agencies such as the DHHSOD have failed to recognize the unique characteristics of children and adolescents with mental health disorders (Bai et al., 2009). This population does not conform to existing service structures and operational criteria. In addition, services for children and youth are fragmented and the financing for these services inflexible. However, coordination between mental health agencies promises a higher likelihood of service and mental health improvements (Bai et al., 2009; Power, 2003; Sayal, 2006). Greater ties between providers of mental health services for adolescents should help mental health
agencies improve both service access and outcomes (Bai, et al., 2009). In addition, linking these systems to prevention and intervention efforts may provide further mechanisms to promote mental health for children and adolescents (see Sayal, 2006).

A major barrier to care for children and adolescents is the discontinuity between mental health service delivery systems and the help-seeking preferences of many families. Mental health services often are provided in a manner that is not responsive to the priorities and needs of families. Glisson and James (2002) noted that many variations exist among mental health agencies in their capacity both to accept innovation and to deliver quality psychiatric services. They argued for the necessity of diagnostic assessments and treatment interventions that are appropriate, valid, and effective for adolescents. In addition, Glisson and James (2002) also noted the importance of adhering to psychiatric treatments, cultivating positive alliances between practitioners and clients, and ensuring that the provision of services is both responsive and continuous.

Other factors that influence self-seeking mental health services include the availability of financial resources (Mechanic, 2008). Access to health insurance influences many young people’s decisions to seek out services, and a family’s ability to pay for these services can severely restrict access. Efforts to lower costs are necessary to guarantee equal access to mental health services for children and adolescents. Samargia, Saewyc, and Elliott (2006) reported the difficulty adolescents encountered in accessing care and focused on factors that may prevent access, including confidentiality, parental decision-making, misidentification of mental health disorders, or misuse of school-based clinics. Although these studies have been helpful in identifying adolescents’ perceived barriers to accessing mental health services, few have focused on the various demographics within the adolescent population or across multiple school and
community settings, and none specifically examined gender differences. Power (2003) and Samargia et al. (2006) recommended that when studying barriers to adolescent mental health access, gender differences must be considered. Finally, health perceptions vary at different stages of the adolescent’s development, so the same barriers may not apply to all age groups.

The current gaps in psychiatric services for adolescents have wide-reaching implications. For example, untreated mental health problems are often an issue for adolescents caught up in the juvenile justice system. In fact, the juvenile justice system has become the largest provider of mental health services for youths and may be the last resort for many mentally ill youth and their families (Kutcher & McDougall, 2009). In addition, many families have made clear their desire for more education, information, and support for their children and adolescents, especially in the early stages of the child’s disorder. Gerson and colleagues (2009) noted the efficacy of specialized treatment programs during the early stages of mental disorders in youth and highlighted the need to address societal stigma and implement structural changes in treatment in order to ensure continuity and coverage of care.

Cultural factors also strongly affect help-seeking patterns. Families from various racial and ethnic groups differ markedly in the way in which they seek mental health assistance. Ethnic families were much less likely than White families of similar socioeconomic background to pursue services from mental health professionals through formal institutions or agencies (Fawcett & Karban, 2005). Stigma, prejudice, and fear are experienced by many people who have mental health difficulties, and Fawcett and Karban (2005) have documented the various dimensions of the relationship between ethnicity, gender, and patterns of oppression and discrimination. Other findings support the claim that racial, ethnic, and language differences are barriers to mental health care access for children and adolescents with chronic emotional
problems—even after their incomes and access to insurance improve (Inkelas et al., 2007). Urban adolescents from ethnic minority groups have disproportionately less access to mental health than their White counterparts. One reason for this discrepancy is the fact that non-White families are more likely to experience poverty, a condition which directly affects adequate access to care (Stern et al., 1999).

For some families, socioeconomic factors may not contribute to their lack of access to care. Even so, and regardless of available managed care coverage, there have been persistent declines in inpatient and outpatient mental health treatment for minority youths both in the general population and for those in child welfare, foster care, or the juvenile justice system (Snowden, Cuellar, & Libby, 2003). For the families involved, efforts to seek out help often include extended families, neighborhood organizations, and faith-based institutions, which suggests that improving access to mental health services requires the development of a service delivery system that is responsive to these family’s cultural needs (Power, 2003). The underutilization of mental health services by ethnic youths compared to White youths persists because of economic and social disparities and contributes to the higher risk of suicide for the former group (Freedenthal, 2007). Another important factor in this service discrepancy is that minority youth may need to turn to community-based resources for mental health care; therefore, the availability of such care may vary by neighborhood, ethnicity, or family preference (Freedenthal, 2007). The best approach may be to provide options for mental health care in readily accessible institutions, such as schools, hospitals, and outpatient mental health programs as well as informal institutions such as neighborhood organizations (Atkins et al., 2003). Furthermore, sustaining community programs includes funding, personnel, and the incorporation
of other resources such as churches, clubhouses, or settlement houses within the community in order to influence adolescent mental health access (Atkins et al., 2003).

Mental health disorders in adolescents are complicated. The resulting response needs to bring together participants from many different systems—all with different objectives, philosophies, and orientations (Mechanic, 2008). Therefore, deciding upon the appropriate care (including the educational system, social services, and the juvenile justice system) and addressing family issues can be extremely challenging. Jacobstein et al. (2007) concluded that the fragmented mental health system (which prevents children with mental disorders from receiving adequate care) and the resulting unmet mental health needs of children and adolescents can lead to problems that become debilitating during adulthood.

The fragmented and categorical structure of children’s services prevents adolescents with more severe mental disorders from receiving appropriate care. Children who seek mental health treatment are bounced back and forth between systems that are often reluctant to bear the costs of their care. These adolescents are consequently at risk for institutionalization, incarceration, placement in the child welfare system, and even removal from their homes. In addition, children and adolescents who experience co-occurring disorders are often overlooked or misdiagnosed, leading to inappropriate or inadequate care (Jacobstein et al., 2007; Pandiani, Banks, Simon, Van Vleck, & Pomeroy, 2005). A lack of adequate mental health services is a major reason for the failure to understand a child’s complex needs; therefore, eligibility requirements for mental health services may be misaligned, leading to disruptions in care. This fragmentation also contributes to gaps in essential community services, rendering specialized services difficult to access (Jacobstein et al., 2007; Pandiani et al., 2005).
Watson, Kelly, and Vidalon (2009) noted that adolescents diagnosed with mental disorders who underutilize services often become involved with the juvenile justice system. Ultimately, the unmet needs of children and adolescents often leave them vulnerable to trauma, abuse, neglect, and other adversity (Vostanis, 2007). In turn, these vulnerabilities lead to a loss of friends, schooling, stability, and other protective influences needed for children’s development and emotional growth.

Transforming mental health services for children and adolescents will require programs that will enable youth to live, work, learn, and fully function in their homes and communities (Kutcher & McDougall, 2009; Stroul & Blau, 2008). Effective evidence-based services that detail practical approaches for implementing family-driven and youth-guided systems are also essential (Stroul & Blau, 2008). High rates of mental health disorders and lack of access—as well as the under-development of appropriate services—continue to adversely affect the treatment of children and adolescents. Consequently, Sayal (2006) and Watson et al. (2009) concluded that the development of effective individualized and community-based services for children and adolescents with mental health disorders is essential for healthy development and later success in life. Mental health problems often have their roots in childhood; unfortunately, a high percentage of these children do not receive adequate care, leading to more severe mental health problems that require far more expensive services during adolescence and adulthood. In fact, less than 50% of children with mental health disorders actually receive any kind of treatment to address their needs (Sayal, 2006; Stroul & Blau, 2008; Watson et al., 2009). Failure to address these needs has serious effects, leading to an overtaxed mental health system and poor health outcomes.
Despite extensive evidence of the need for mental health services for adolescents, the literature continues to note poor mental health service utilization due to reduced access and engagement, and based on the fact that the mental health needs of children do not conform to existing treatment service structures and operational criteria (Vostanis, 2007). These barriers often leave parents feeling disappointed and frustrated as they watch their children languish without the needed care, and this despair may eventually cause them to relinquish custody to public child welfare authorities (Stroul & Blau, 2008). On the other hand, adolescents can benefit from inclusive services such as respite care, crisis behavioral supports, home-based behavior intervention, appropriate after school care, and adequate supports for family caregivers.

Perceptions of mental health treatment may also be a barrier hindering adolescent mental health treatment. Some families may prematurely terminate services for their children based on the relationship between provider and parent, stressors related to treatment, and concerns about the importance of treatment. In fact, Stevens et al. (2006) found that mental health utilization is unrelated to socio-demographic status or financial problems; instead, the strongest correlation to termination of mental health services was the perceived irrelevance of treatment and relationship problems between the clinician and the family. However, this study was limited because it did not include the adolescent’s perspective on the client-provider relationship. Adolescents may have valuable untapped insights into the reasons for the premature termination of their mental health treatment. This study also utilized parent interviews and concluded that the parents are the key decision makers regarding their children’s health care utilization (Stevens et al., 2006). Future research on the adolescent-provider relationship would benefit from including the perceptions of the adolescents themselves in order to understand their utilization of outpatient psychiatric care.
Positively defined, mental health implies the ability to achieve developmentally appropriate tasks or to develop competence in certain areas (Beardslee, Chien, & Bell, 2011). For example, adolescents between the ages of 12 and 18 typically have the capacity to establish new and mature relationships with members of the opposite gender, achieve sexual and gender identity, be happy with their physique, learn how to use their bodies effectively, achieve emotional independence of parents and other adults, prepare for a career, acquire a set of values and an ethical system as a guide to behavior, and develop ideologies and socially responsible behaviors (Irvin, 1996). Adolescent acceptance of mental health treatment includes concerns about confidentiality and the attitude of peers, barriers to adolescent mental health utilization that can predict poor outcomes in obtaining mental health treatment (Stiffman, Striley, Horvath, Hadley-Ives, Polgar, Elze, & Pescarino, 2001; Wisdom et al., 2006). For example, depression is the major common psychiatric disorder among adolescents, is associated with an increased risk of suicide, and accounts for a substantial portion of the healthcare costs incurred by this age group; however, less than half of adolescents who experience depression seek treatment (see Wisdom et al., 2006). The nature of their emotional problems may make teens reluctant to discuss these issues with their parents, and parents may consequently be more likely to overlook depression and other internalizing disorders because these issues manifest in less disruptive ways than behavioral disorders. Although adolescents may have more avenues for obtaining help than children, they may resist adults’ attempts to convince them to seek this help (Campo, 2009; Meredith, Stein, Paddock, & Jaycox, 2009). In addition, adolescents may experience difficulty accessing mental health services because they are still under the care of their parents or legal guardians, and in most instances guardian permission is needed for access to services and to insurance.
Although adolescents often have a legal right to consent to care independently of their parents, most are probably not aware of their legal rights (Kuther, 2003). It is possible that if more adolescents were informed of their legal right to consent for treatment, most would independently seek treatment and services. Adolescents are mindful of and deferential to parents but are more likely to resist parental influence when they perceive that the consequences of their decisions may have serious health implications. With increasing age, adolescents are better able to understand and recognize the interests of their parents or guardians but are also more likely to consult independent sources of information when making decisions regarding their health (Kuther, 2003). These independent sources include mental health practitioners, who for a number of reasons are important to adolescents in accessing mental health services. Young people often seek advice, encouragement, and support when encountering emotional and mental disorders. Subsequently, they tend to be directed to services by parents, teachers, physicians, juvenile justice authorities, social workers, and other adults. Practitioners can define their roles as gatekeepers to mental health care for this population.

Gaps in adolescent access and utilization of mental health services may in part be attributed to practitioner perceptions of the informed-consent process, legal and policy practices and ethical issues around informed consent, and the perceptions of an adolescent’s capacity to consent. The question of how practitioners experience informed consent for adolescent mental health access and utilization requires further study (Stiffman et al., 2001). For example, how does consent impact adolescent engagement in mental health treatment? What is the experience of practitioners in obtaining consent in order to engage an adolescent in mental health treatment? How does the practitioner experience the impact consent has on building relationships with adolescents? In order to answer these questions, an open dialogue must occur.
Informed Consent

The Definition of Informed Consent

Informed consent is the willing acceptance of a specified medical intervention by a patient after adequate disclosure by the practitioner of the nature of the intervention, its risks and benefits, and the consequences of refusing or accepting treatment; the consent must also be given voluntarily and freely (Bello, 2010; Schmidt & Reppucci, 2002; Scott et al., 1995). The term implies that there is consent for a practitioner to become involved with the patient to render a specific treatment about which the patient has been adequately informed. The absence of consent negates the entire process of treatment, and there can be serious liability on the part of the practitioner for engaging in treatment without consent or for violating the patient’s legal and ethical right to privacy (Bello, 2010).

The following elements of informed consent are examined in this literature review: (a) capacity (b) confidentiality and (c) self-determination. First, capacity or competence may be defined as an individual’s ability to render consent. In mental health, the term capacity is used to refer to the ability to give valid informed consent or refusal of treatment. Capacity is decision-specific and relates to the specific treatment being proposed to a patient in a specific situation under specific conditions. Mental capacity or competence is a prerequisite of informed consent and the nature of capacity varies among state jurisdictions (Roberson, 2007; Scott et al., 1995). Adolescent competence has been analyzed within an informed-consent framework that incorporates the decision-making process, which includes an understanding of the risks and benefits of the decision. To this end, competent adolescents have the ability to realistically appraise the outcome of their decision and are able to justify their choices (Roberson, 2007; Weithorn, 1982).
Informed consent requires that patients receive adequate disclosure of necessary information regarding treatment. The information disclosed should relate to the nature of the proposed treatment; the benefits, risks, and side effects of any treatment; any alternative courses of action that could be pursued; and the consequences of the decision to have or not have treatment (Roberson, 2007; Schachter et al., 2005). The consent should also be given voluntarily and be free of any coercion, force, or manipulation. The process of informed consent is dynamic and occurs throughout the relationship between the practitioner and patient. It begins with information sharing and the diagnosis of the mental health disorder, and it is preceded by the patients’ understanding of their mental illness and their consequent determinations concerning their care (Roberson, 2007; Schachter et al., 2005).

**Legal issues related to Informed Consent**

Many states require that a “competent adult” consent to care. Almost all states set the definition of adulthood at age 18, in which case no consent on the part of a parent or guardian is required. Marriage, military service, parenthood, or independent living apart from parents may serve to emancipate adolescents and place them in the legal category of an adult (Bello, 2010; Campbell, 2006). To date, greater flexibility is emerging in legal interpretations of consent, allowing adolescents to make certain health and mental health decisions for themselves. For example, in New York State, a minor under the age of 18 can consent to his or her own mental health treatment, but only under the following circumstances:

1. the minor is knowingly and voluntarily seeking such services; and
2. provision of such services is clinically indicated and necessary to the minor's well-being; and
3. (i) a parent or guardian is not reasonably available; or (ii) requiring parental or guardian consent or involvement would have a detrimental effect on the course of outpatient treatment; or
   (iii) a parent or guardian has refused to give such consent and a
physician determines that treatment is necessary and in the best interests of the minor. The mental health practitioner shall fully document the reasons for his or her determinations. Such documentation shall be included in the minor's clinical record, along with a written statement signed by the minor indicating that he or she is voluntarily seeking services. As clinically appropriate, notice of a determination made pursuant to subparagraph (iii) of paragraph three of this subdivision shall be provided to the parent or guardian. (d) a mental health practitioner may provide a minor voluntarily seeking outpatient services an initial interview without parental or guardian consent or involvement to determine whether the criteria of subdivision (c) of this section are present (Consent for Mental Health Treatment of Minors, 2015.)

These legal statues serve as a guideline for clinicians; however, adolescent informed consent needs to be understood in and under specific and context-sensitive situations or conditions, making practice issues for practitioners challenging and difficult.

**Ethical Perspectives on Informed Consent**

Clinical ethics, as a framework, concerns autonomy, beneficence (the desire to do good), non-maleficence (the duty to do no harm), and the legal rights involved in the consent process. This framework emerged in the 1970s due to concerns about who should make these decisions, how they should be made, and what circumstances would allow them (Beauchamp & Childress, 1994; Campbell, 2006). The ethical dilemma for practitioners, within this framework, centers on acting in the best interests of the adolescent. In these cases, several questions naturally arise: What is morally correct? What is the practitioner’s experience with the presenting issues of the young person? If the young person presents with a mental illness, does he or she have the capacity to make decisions regarding treatment? Is the practitioner willing to take legal responsibility for the adolescent’s decision? When answering these questions, practitioners should be guided by four ethical principles that include self-determination, policy, ethics, and beneficence (Beauchamp & Childress, 1994; Campbell, 2006).
The ethical and legal right to render consent involves no interference with the adolescent’s choice of treatment and assisting him or her in securing the treatment goals. Competent and capable adolescents have the right to make decisions for themselves and for those decisions to be upheld according to their value system (Weithorn, 1985). Typically, family members or other legally valid persons are permitted to consent or refuse on another person’s behalf when the individual lacks the capacity to do so. However, adolescents should be encouraged by practitioners to participate in the decision-making process. For the purposes of this dissertation study, adolescents age 14 and older will be defined as those having the capacity and competence to provide informed consent for their own care. Schachter et al. (2005), Vukadinovich (2004), and Weithorn and Campbell (1982) concur that minors age 14 and older have the cognitive capacity to make complex decisions necessary for consent.

**Practice issues with Informed Consent**

In general, individual states tend to limit adolescent decision making to outpatient settings. However, the trend is shifting to allow adolescents to consent in situations where the risks of not seeking care are greater than the risks of not obtaining parental permission (Bello, 2010; Campbell, 2006). Many professional organizations support adolescent participation in decisions regarding the adolescent’s health and their standards of practice therefore encourage this participation. For example, Principle IV of The American Academy of Child and Adolescent Psychiatry (2009) Code of Ethics states the following:

Situations arise in which the desires of the child or adolescent and their guardian(s) conflict. When the youngster dissents but the guardian consents to treatment, it may be medically necessary to treat the individual minor without his or her concurrence. In such cases, the child and adolescent psychiatrist should carefully consider the health needs of the child or adolescent and the psychological ramifications of treating
that individual against his or her wishes. To facilitate collaborative relationships with minors and their guardians, and to enhance patient autonomy, the child and adolescent psychiatrist should communicate to them, at all times, information that conveys sufficient understanding of the case situation and a thorough explanation of the professional judgments, opinions and factors that guide the child and adolescent’s psychiatrist’s actions and recommendations for treatment. (p. 6)

However, if clinicians have specific questions about how to proceed with adolescent informed consent, they are urged to consult a legal authority for guidance. For practical reasons, clinicians prefer to obtain parental consent because it absolves them from liability.

**Capacity and Competence in Informed Consent**

**Assessing Capacity and Competence in Clinical Practice**

Capacity is the ability to make treatment decisions on one’s own behalf. Researchers have shown that children acquire the capacity to make treatment decisions by the age of 9 and by the age of 14 are fully capable of more complex health care choices (Tan et al., 2007; Weithorn & Campbell, 1982). During adolescence, the developmental period spanning age 11 to young adulthood brings forth a gradual development of values and maturity, increasing the ability to make autonomous or self-defining choices (Crain, 2000). Classical theorists of adolescent development focus on the progress of adolescence through several stages (Erickson, 1968; Wadsworth, 1984). In Piagetian terms, cognitive development in children and adolescents represents increasingly comprehensive ways of critical thinking: children are constantly exploring, manipulating, and attempting to make sense of a complex environment, and throughout this developmental process they are actively constructing new and elaborate structures to deal with their environment (Crain, 2000). According to Piaget’s theory of development, children reach the stage of formal operations by the age of 11 (Piaget, 1977;
At this point, children begin to think logically and in hypothetical terms, therefore enabling them to become autonomous and develop the capacity for decision making. Other developmental theorists like Erickson (1968) focused on identity formation and how adolescents become aware of the differences between who they are with others and who they are privately.

Contemporary theorists like Baker and Coe (1993), Manning (1990), and Neinstein (1996) offer lists of developmental tasks linked to various stages of adolescence. These include achieving independence from parents, adopting peer lifestyles and codes of behaviors, accepting body image, and establishing vocational and moral identities. However, a debate remains within the mental health community concerning the precise moment when adolescents develop the sufficient capacity to make decisions about their own care and about whether they are developmentally mature enough to consent for treatment. Within adolescent mental health care, protective treatment policies are usually based on the presumption that adolescents differ from adults in their capacities for reasoning and appreciation as well as in their ultimate decisions (Schachter et al., 2005).

In mental health care, determining capacity may pose a challenge. Mental health disorders often manifest differently in terms of symptoms, and their presentation may therefore be different for each teen. In addition, presentation and course of illness may vary based on internal or external factors, such as genetics, family situation, community support, or coping mechanisms. Subsequently, adolescents with mental disorders may have differing capacities at different points in their illness, depending on symptoms, medication, and treatment (Campbell, 2006; Schachter et al., 2005; Tan et al., 2007). In a study on adolescent mental health treatment, Kaser-Boyd et al. (1985) focused on adolescents’ concept of the risks and benefits of outpatient
mental health treatment. The population sampled was adolescents with a median age of 12-15 who were either referred for psychotherapy or were potential candidates for treatment. The results of the study revealed that most of the minors in the sample were able to identify at least one risk or one benefit involved in therapy. The findings appear to suggest that, in general, minors are able both to identify risks and benefits and to use abstract concepts in their discussion of these risks and benefits.

**Legal aspects of Capacity and Competence with Informed Consent**

Children and adolescents may encounter a mental health care system that encourages autonomy, yet the legal system often considers them “minors” who are without any decision-making authority. The matter of informed consent in this area is rendered even more complex when providers do not view adolescents as competent to provide legally binding consent regarding their own care. This opinion is often not solely due to a perceived lack of maturity, but also because the nature of the mental illness might result in impaired reasoning. For example, a young person who experiences active hallucinations may be less likely to be able to render informed consent for treatment and, therefore, needs someone to act on his or her behalf (Walker, Brooks, & Wrightsman, 1999).

There is a general principal in health care that informed consent is a precondition for intervention (Alderson, 2007). The issue of adolescent consent for treatment, however, brings with it controversy regarding competence and capacity. Competence is concentrated on how an adolescent’s changing status as a competent decision maker influences his or her ability to consent. The legal criteria for competence includes understanding the relevant information, retaining the information, weighing the information in order to make reasoned choices, and
making voluntary and autonomous decisions based on this information. Consequently, consent involves the concepts of competence, respect, and dignity and the capacities for informed choice and understanding—all of which may be difficult to define and assess (Alderson, 2007; Ascherman & Rubin, 2008; Schachter et al., 2005; Turner-Henson, 2005).

The concepts of informed consent are consistent with the principles set forth in the United Nations Convention on the Rights of the Child, which argue that children should have the right to express their own views (see Office of the High Commissioner for Human Rights, 1990, Article 12). To this end, clinicians should consider the child’s preferences, the treatment approaches, the risks involved, and child’s stage of development (Walker et al., 1999). Under English common law, which is applicable in many countries around the world, the “Rule of Sevens” is used to measure children’s capacity: Between the ages of 1-7, there is an irrefutable presumption that a child has no capacity; between the ages of 7-14, there is a rebuttable presumption that a child has no capacity; and between the ages of 14-21, there is a rebuttable presumption that a child has capacity (Bello, 2010).

The competency of adolescents to make decisions about their own health care has consequently become a topic of research whose aim is to provide an empirical analysis of the degree to which legal-age standards for consent and refusal of treatment are consistent with the chronological psychological skill development required to render competent treatment decisions (Schachter et al., 2005; Vukadinovich, 2004; Weithorn & Campbell, 1982). Studies conducted by Weithorn and Campbell (1982), Vukadinovich (2004), and Schachter et al. (2005) concluded that adolescents age 14 and older do not differ from persons defined by law as adults in their capacity to provide competent informed consent and refusal for medical and psychological treatment. Despite the assumption that parents are best suited and most inclined to act in the best
interests of their children, concerns for privacy in care and confidentiality of health care information can affect if, when, and how adolescents seek out care (Forehand & Ciccone, 2004; Martindale, Chambers, & Thompson, 2009).

**Ethical Considerations with Capacity and Competence**

Mental health practitioners are confronted with a constant flux of emotional and physical developmental changes during an adolescent’s development. The determination of capacity is an ongoing and ever-constant process and cannot be fully determined during a single session or evaluation. Several studies (Campbell, 2006; Schachter et al., 2005, Scott et al., 1995; Tan et al., 2007) therefore recommend that practitioners should ponder the following questions when providing psychiatric care to adolescents: Is informed consent in the absence of a parent or legal guardian required in order to engage the adolescent in mental health treatment? Will the adolescent’s informed consent enhance the therapeutic relationship? Is the adolescent in any kind of imminent danger or at risk for harm? If so, has the practitioner informed the parent? Are the privacy interests of the adolescent and family being considered? Is the clinician acting in the adolescent’s best interests and taking into consideration the adolescent’s self-determination? Ethical perspectives on adolescent consent in mental health treatment focus on the desire to build therapeutic relationships between the adolescent and practitioner. Clinicians have the ethical burden of balancing adolescent interests with parental influences—all the while helping adolescents to maintain healthy relationships within their families and to utilize mental health services.
Confidentiality in Informed Consent

Practice Considerations and Confidentiality

The issue of adolescent consent for treatment brings with it controversies regarding confidentiality. Societal threats (such as substance abuse and crime) have created a need for information sharing amongst practitioners, agencies, families, and law enforcement units in order to protect the well-being of children and adolescents. Research suggests that adolescents remain reluctant to enter into mental health treatment, citing confidentiality as their salient concern (Isaacs & Stone, 2001; Tan et al., 2007; Taylor & Adelman, 1989). For practitioners, treating adolescents with truthfulness, consideration, and personal respect and involving them in goal setting are important in establishing a trusting relationship that can help bridge concerns about confidentiality. Clinicians are faced with the task of establishing a trusting therapeutic climate that will ensure engagement and the continued utilization of mental health services. Consent and confidentiality play a vital role in clinical practice to ensure that clients receive adequate disclosure of mental health information.

Studies indicate that a helpful way to approach confidentiality entails being aware of the clinical context and dynamics that protect and optimize the health and safety of adolescents receiving mental health care (Isaacs & Stone, 2001; Tan et al., 2007; Taylor & Adelman, 1989). For example, a clinician might inform a minor, “This is what I want to talk to you and your parents about, and here are the reasons why. Is that okay with you? Are there any parts we should keep between the two of us?” (see Schachter et al., 2005; Tan et al., 2007). Approaching confidentiality in this manner will ensure that there is recognition of the adolescent’s cognitive, social, and emotional development and also imply a recognition of the adolescent’s
vulnerabilities. Moreover, by involving the young person in these privacy issues, the clinician cultivates a trusting relationship that can support and foster therapeutic alliances.

Mental health practitioners are also guided by professional organizations and state organizations, such as the National Association of Social Workers, American Psychological Association and the New York State Office of Mental Health, that support the provision of confidential care to adolescents seeking both medical and mental health services. From a developmental perspective, confidentiality in adolescent care has been justified by this population’s expanding desire for autonomy and increasing capacity as they age. A dated yet relevant study conducted by Gustafson and McNamara (1987) recommended that practitioners should utilize Piaget’s and Kohlberg’s stages of development to decide which information should remain confidential and to identify adolescent capacity in the decision-making process. Taking a developmental approach to discussing privacy concerns with adolescents helps practitioners navigate the ethical and legal issues affecting confidentiality.

**Legal Considerations**

Confidentiality for adolescents is protected in order to safeguard the health of those who will not seek services if their privacy cannot be guaranteed. Currently, the United States supports adolescent confidentiality laws in health and mental health, allowing practitioners to determine when disclosure to parents or legal guardians is warranted. However, recent attempts to limit a minor’s access to confidential services for sensitive health care issues have threatened the alliance between health and mental health (Ford & English, 2002). Research has demonstrated that even though confidential health services are available, many adolescents limit their use of these services based on a fear of breach of privacy (Campbell, 2006; Schachter et al.,
2005; Tan et al., 2007; Taylor & Adelman, 1989; Taylor & Adelman, 1998). This fear remains the salient factor in preserving confidentiality and adolescent informed consent.

In a large nationally representative survey conducted by Klein, Wilson, McNulty, Kapphahn, and Collins (1999), approximately one quarter of middle school and high school students reported that they did not seek required health care out of fear of privacy breaches. The researchers found that 35% of students who did not seek care reported that one reason was their refusal to disclose the care to their parents. When adolescents with privacy concerns do seek care, many delay obtaining care and/or deliberately choose sites that offer confidential care, such as adolescent health centers or family-planning clinics. In New York State, adolescent health centers provide confidential health care in comparison to outpatient mental health clinics where confidentiality is based on adolescent capacity. Some adolescents also limit their communication with practitioners about sensitive health topics. Therefore, practitioners face ethical, legal, and practice concerns when rendering psychiatric services to minors.

Studies (see Gustafson, McNamara, & Jensen, 1994; Martindale et al., 2009) have shown that adolescents appear to have a desire for confidentiality, and both adolescents and clinicians revealed an interest in discussion of confidentiality, disclosure, and therapeutic benefits. Additionally, severity and risk were also important to the parental decision-making process when it came to helping children receive treatment. Parents who have positive attitudes toward mental health emphasize confidentiality and view therapy and mental health treatment disclosure issues as potentially beneficial (Jensen et al., 1991). These preferences may be a function of parents’ knowledge and understanding of confidentiality and mental health services. Parents and clinicians alike indicate similar interests in confidentiality and disclosure issues regarding treatment for children (Jensen et al., 1991). These interests include protecting the welfare and
safety of the young persons involved in mental health services. Absolute privacy is not possible in all situations, especially when there is a concern about risk; therefore, professional guidelines, organizational rules, and/or moral/ethical codes may provide practitioners the opportunity to explain their obligations to adolescents. However, in doing so, practitioners may experience ethical dilemmas about how to do so and at the same time keep the adolescents in treatment and maintain therapeutic trust.

**Ethical Considerations and Confidentiality**

There are times when practitioners would prefer to maintain strict privacy with adolescents but cannot do so legally or ethically. For example, when a young person indicates an intention to self-harm or to harm others or in cases of abuse, the law dictates that confidentiality must be breached in order to safeguard the parties involved and inform the appropriate authorities, including parents or legal guardians (Tan et al., 2007). Unfortunately, this breach of privacy may often interfere with the trust and therapeutic alliances practitioners attempt to maintain with adolescents and their families. This conflict presents a clear dilemma when working with adolescents. The assessment of capacity is intertwined with either maintaining or breaching privacy. How can practitioners act in the best interests of adolescents when mental health is an issue? How can they continue to engage the adolescent in treatment when the parents threaten to withdraw him or her from care due to restricted access to information? These questions are not easy to answer and are complex in nature.

While there is respect for adolescent confidentiality, practitioners are obligated to consider the severity of the mental illness when determining the adolescent’s capacity to consent for treatment (see Campbell, 2006; Tan et al., 2007; Taylor & Adelman, 1998). For instance, an
adolescent who presents with a psychotic disorder may not possess the cognitive or developmental ability to deal with the information and issues surrounding his or her mental health situation. The adolescent may still reside at home with the parents, who retain responsibility for directing care. The adolescent may wish for boundaries and confidentiality; however, the nature, scope, and severity of the mental illness in question may warrant a breach of privacy, and the practitioner may decide to engage family members, social services, the schools, or other health professionals in order to best coordinate treatment. The literature, as referenced thus far, seems to suggest that practitioners should always attempt to build trust and work through the issues of privacy by informing adolescents of situations that may require a breach of privacy.

Adolescent Self-Determination in Informed Consent

Legal and Ethical Considerations and Self-Determination

To date, only a few studies have explored varying perceptions and experiences regarding adolescent participation and decision making for mental health treatment. Research on the provision of mental health services to adolescents has focused primarily on the perspectives of caregivers (see Munson et al., 2009). Melton (1983) observed that since the 1960s, there has been a movement to extend minors the same legal rights afforded to adults. One of the protections adults have is the right to receive informed consent prior to receiving mental health treatment. Teenagers, however, seeking mental health care treatment often encounter a paradox: an ethical code that supports their right to self-determination, but a legal system that defines them as “minors” with limited decision-making authority or autonomy. Additionally, there is a paternalistic view within society that assumes that adults are better equipped to direct adolescent
healthcare decisions. Teenagers tend to express their desire for dignity and respect by demanding more independence and confidentiality in making decisions about their own affairs (see Bello, 2010).

Article 12 of the United Nations Convention on the Rights of the Child recognizes the importance of respecting the views and opinions of children who are capable of self-determination:

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law. (Office of the United Nations High Commissioner for Human Rights, 1990, Article 12, p. 4)

The United States has not yet ratified the recommendations on self-determination made by the Convention on the Rights of the Child. Instead, each state has its own definition regarding the status and nature of adolescent autonomy. Depending on the jurisdiction involved, informed consent requirements for health service providers may be an ethical matter, a legal matter, or both (Bello, 2010).

In many states, minors are granted the right to consent to mental health treatment independent of their parents and can also consent to substance abuse treatment and reproductive health services (Campbell, 2006). In situations where obtaining parental consent may decrease the likelihood that adolescents will seek help, they are able to consent for their own treatment. However, Blankenship, Eells, Carlostzi, Perry, and Barnes (1998) and Garland, Aarons, Saltzman, and Kruse (2000) underscored the fact that adolescents are often referred for therapy by a third party (a parent, teacher, court, or juvenile justice system); consequently, their sense of
autonomy and freedom is threatened regardless of their ability to consent for their own treatment. In addition, most clinicians do not pursue informed consent with adolescents. Because of these noted circumstances, adolescents often do not have sufficient information regarding the positive features of therapy and, consequently, will not have the necessary autonomy to make decisions regarding treatment.

**Practice Considerations and Self-Determination**

Adolescents granted autonomy to seek their own mental health treatment appear to experience greater positive perceptions of services than those who were not (Munson et al., 2009). Additionally, adolescents who are directly involved in the decision to enter treatment report significant satisfaction and retention rates compared to adolescents who are referred by parents, school professionals, or other mental health or health care professionals (Garland et al., 2000).

In a significant study that surveyed adolescent attitudes toward mental health treatment (Taylor et al., 1985a), the majority of adolescents indicated a desire to be involved in decisions, perceived themselves as competent to do so, knew what outcomes they sought, and followed through when given the opportunity. The researchers were principally investigating adolescents’ perceptions of their competence in decision-making and the perceptions of professionals about this same competence on the part of adolescents. The sample consisted of 81 children, adolescents, and young adults between the ages of 7 to 20 who attended school or college. The major variables explored were participation in making decision, the perception of the child’s or adolescent’s competence to participate in these decisions, and the interest in instruction designed to increase competence. The results indicated that a high proportion of the respondents were
interested in participating in the decision-making process and perceived themselves and others as competent to do so. The research suggested that judgments about a young person’s lack of competence to participate in decision-making may reflect the lack of opportunities allotted to them to learn how to participate capably. The study highlighted the value of offering this instruction in order to increase participation in decision-making.

Practitioners are encouraged to accommodate differences in levels of motivation and development in order to understand whether adolescents have the capacity and competence to consent to their own mental health treatment. Access to information about mental health and taking an active role in the decision-making process may help facilitate adolescent engagement and influence the use of and outcomes for outpatient mental health services (Adelman, Kaser-Boyd, & Taylor, 1984; Beeman & Scott, 1991; Taylor et al., 1985a; Weithorn, 1985). Mental health interventions that focus on self-direction and autonomy may help foster an environment and/or therapeutic relationship in which adolescents feel heard and respected. Such an environment or relationship may prevent clinicians and family members from being pulled into an oppositional, frustrating, and losing struggle with adolescents, especially if the adolescents are referred by others (Blankenship et al., 1998). Providing adolescents with decision-making authority might help to ensure that they are receptive to mental health treatment and empowered to obtain it if necessary. To this end, granting adolescents decision-making power may also ensure that parents or guardians do not choose a mode of treatment that may be overly restrictive or mismatched clinically (Vukadinovich, 2004).
**Treatment Practices and Consequences**

Practitioners and administrators frequently debate how best to ensure that adolescents get the care they need while at the same time respecting parental or legal-guardian rights and family interests. As a result of the conflict between these sets of competing interests, adolescent treatment dropout rates remain quite high, leading to fragmented delivery service and poor health outcomes (Jivanjee et al., 2009). Practitioners are often inclined to obtain parental consent for adolescent treatment because it can insulate treatment providers from undue criticism, complaints, and potential litigation. Obtaining parental consent is perceived by practitioners as essential in clinical practice because adolescents are thus guaranteed adequate disclosure of information concerning the risks and benefits of treatment (see Hickey, 2007; Schachter et al., 2005; Tan et al., 2007). In two studies conducted by Taylor et al. (1985a; 1985b), practitioners’ perceptions regarding adolescent mental health treatment appeared to be a stronger force in shaping clinical practices than legal guidelines for informed consent. The first study focused on adolescents’ involvement in decision making, and the second examined how practitioners involved adolescents in informed consent. A survey method was used that included both direct questions and a set of vignettes with response alternatives. The survey was administered in school and college settings. The survey focused on the ages during which adolescents engage in decision making for matters and situations in which they generally have decision-making autonomy. The age range included children and adolescents from 6-20 years. The respondents overwhelmingly reported that the age for autonomous adolescent decision making should be 15. Conversely (and significantly), 83% of the parents surveys believed that parents, teachers, and society in general are too permissive in regards to autonomous adolescent decision making.
At the time of the second study, California state law required parental consent for mental health treatment for adolescents under the age of 18 (Taylor et al., 1985b). For the purposes of the study, the researchers were most interested in clinical informed-consent practices and whether adolescent involvement in informed consent is consistent with the adolescent’s views and those of the parents/guardians. A survey designed to measure informed-consent practices was mailed to a sample of 669 mental health professionals. This survey was designed specifically to assess perceptions and attitudes regarding informed-consent procedures for adolescents. The results indicated that 48% of practitioners asked adolescents to provide their own consent in addition to the parents’ consent. The findings in this study suggested a potential conflict between the client’s and the practitioner’s views about an adolescent’s participation in informed-consent procedures. The fact that the majority of professionals in the sample did not ask for adolescents’ consent for mental health services raises the potential for competing interests between adolescents and their parents. The question arises as to how the involvement of minors in age-appropriate decisions can be more consistently incorporated into mental health policies and practices. When policy or prevailing practices dictate that adolescents cannot or should not participate in mental health treatment decisions, the rationale is often that the adolescents are unable to make informed decisions. This rationale is based on the assumptions that adolescents prefer immediate gratification and that they have a tendency to ignore long-term consequences of their actions. But such behavior may be an indication of the insufficient information that adolescents are given and which would allow them to make informed decisions. Further research should continue to examine how practitioners understand, perceive, and seek adolescent informed consent.
Similar to Taylor et al. (1985a; 1985b), Kaser-Boyd et al. (1985) conducted another study aimed at examining the concerns practitioners have that adolescents are being coerced into therapy and may therefore become bored with the sessions, resulting in limited access and retention. This study also revealed that adolescents are able to identify the risks and benefits of therapy and that their concerns appear to be relevant to their developmental needs. Awareness of risk and benefits remains important to the parental decision-making process when it comes to helping children receive treatment. Therefore, clinicians are more likely to involve parents throughout the treatment process.

In addition, risk behaviors common to adolescents also present practitioners with ethical challenges regarding consent. For example, risk behaviors such as suicide lead to high mortality rates among adolescents; therefore, additional research is needed to comprehend the dangers and protective factors for these behaviors. It is also crucial to determine the prevalence of mental disorders and to develop and evaluate intervention strategies aimed at preventing mental illness and the disabilities it can cause (King & Kramer, 2008; Olds, 2003). When attempting to promote the mental health of adolescents, it is essential to understand and identify key factors that may be linked to increased risk behaviors.

Mental health practitioners working with adolescents and their families must attend to several ethical concerns that compete and that typically do not come into play with adult clients. Competing interests between adolescents and their families is one area that requires consideration. Most families include members whose interests do not align perfectly, and mental health treatment with adolescents involves multiple relationships, including those between mental health practitioners, parents, and the adolescents themselves (Koocher, 2008). Mental health practitioners need to carefully consider to whom they are responsible and to assess these
competing interests in order for the adolescents to achieve the maximum benefits of treatment and support (Koocher, 2008).

Practitioners may also need to consider what oversights by external organizations can support and sustain adolescent access to mental health services. Without question, perhaps one of the greatest challenges facing providers who work with adolescents in need of mental health services is the lack of consistent, constructive, and sustained oversight in treatment programs. According to Behar, Freidman, Pinto, Katz-Leavy, and Jones (2007), there is usually no consensus among professionals in the field of adolescent services that oversight and regulation should be necessary and consistent. The Office of Mental Health licenses outpatient mental health clinics in New York State and promulgates ethical standards and regulations for good practices, but these standards and regulations are left up to clinics or programs to interpret and implement. What may result from this laissez-faire approach are inconsistent practices among clinics. For example, the New York State Office of Mental Health (NYS OMH) does not specifically oversee the informed-consent process for adolescents seeking mental health. Instead, policies and practices regarding informed consent for adolescents remain under the discretion of the individual clinics. Within each program, practitioners may then choose between parental consent and adolescent-informed consent, a choice which may result in conflicting policies between programs, providers, adolescents, and their family members.

Furthermore, providers may be confused about how to proceed when parents and adolescents have conflicting opinions regarding mental health treatment; out of fear of the legal consequences, some mental health programs may even defer treatment when parental consent has not been obtained. Amid such confusion, outpatient clinics may allow adolescents to terminate treatment despite the fact that the adolescents can benefit from mental health services
provided. The range of legal, social, ethical, and policy-related issues resulting from treating adolescent psychiatric disorders complicates efforts at early and effective intervention and affect diagnosis and treatment. Additionally, providers are faced with disparities in insurance coverage as well as higher expenses for psychiatric care, the stigma associated with mental health disorders, and limitations in treatment and research initiatives due to legal restrictions—all of which affects the degree of confidence that providers may have in the services they provide. Faced with so complex a picture, Campbell (2006), for instance, has encouraged clinicians to consult legal counsel in order to best understand applicable state law and local regulatory guidelines. Furthermore, these ethical concerns may serve as an impetus for the inclusion of adolescents in treatment decision making (e.g., providing access to information and giving them an active role in decision making) and may facilitate the therapeutic process, thus improving their mental well-being (see Aarons, 2004; Beeman & Scott, 1991; Roberson, 2007; Schachter et al., 2005).

Mental health informed-consent practices for adolescents are varied and often at odds with the ethical and legal issues surrounding the capacity and competence of adolescents to consent for treatment. This process is often ambiguous and may differ by state. As previously mentioned, this dissertation study sought to understand the outcomes and treatment practices with regards to adolescent informed consent. Beeman and Scott (1991) examined practitioner perceptions and attitudes regarding adolescent involvement in informed consent for outpatient mental health and revealed several major reasons mental health practitioners give for not requesting adolescent informed consent; their findings revealed concerns about the perception of adolescent refusal for treatment and the fact that, when informed consent was not legally required, the usual practice was to not request it. Beeman and Scott (1991) used a quantitative
survey analysis designed to investigate practitioners’ attitudes toward the provision of informed consent for outpatient services to adolescents. The 77-item 5-point Likert survey was mailed to a national sample of 255 psychologists who provided outpatient psychotherapy to adolescents. The survey was intended to assess clinician’s attitudes and practices regarding adolescent informed consent for psychotherapy. The findings revealed that 93% of these clinicians indicated that they generally gained informed consent from the parents of adolescents; however, 70% of the clinicians would rather request informed consent from the adolescents themselves. Only a mean of 11.3% of adolescents were estimated to not have sufficient comprehension to render valid consent. Analysis revealed that obtaining parental consent and gaining adolescent consent were significantly correlated. This study clarified the effects of informed-consent procedures on treatment processes and outcomes as well as adolescent engagement and utilization of psychotherapy services.

Clinicians need to involve adolescents in the informed-consent process to the greatest extent possible and assess their capacity to consent for treatment on an individual patient-by-patient basis, recognizing that capacity may evolve as adolescents’ cognitive abilities and values develop (Schachter et al., 2005). Further empirical data concerning practitioner experiences for adolescent informed consent provides an opportunity for the development of more informed policies and standards regarding consent (Miller, Drotar, & Kodish, 2005).

**Informed Consent: Gaps and Limitations**

Adolescents with little understanding of mental health disorders, treatments, and consequences cannot adequately understand the process of informed consent and their right to self-determination in their own mental health treatment (Chandra & Minkowitz, 2007). As
previously mentioned, studies have revealed that adolescents want to participate in decisions regarding their mental health treatment and are interested in learning how to participate effectively in such decisions (Kaser-Boy et al., 1985; Taylor et al., 1985). Further research in this area can identify significant gaps and suggest alternative ways that practitioners can offer information resulting in effective participation of adolescents in their own mental health care. In addition, mental health practitioners should acknowledge that adolescents who seek services may hold stigmatizing attitudes towards these services or have individuals in their personal networks that hold such attitudes. Therefore, addressing adolescent perceptions of mental health services and identifying potential biases are integral to retention.

Future studies may help practitioners understand adolescent informed consent, which can ensure that young people are receptive towards and empowered to obtain the necessary mental health treatment. It is possible that if practitioners become more knowledgeable about how to engage adolescents in informed consent and consider the influence of adolescent decision making in mental health treatment, they may improve engagement and retention rates for mental health treatment. Such changes can be facilitated through the development of appropriate psycho-education programs that focus on practitioner and adolescent awareness of the informed-consent process. Knowledge gained from additional studies would consequently provide parents, clinicians, and legislators with the necessary information to make informed decisions regarding the formation of policy and the implementation of practice approaches concerning adolescent informed consent.
Chapter III: Research Methodology

As discussed in the literature review, few empirical studies have addressed how informed consent affects treatment practices and outcomes for adolescents. Limited information is also available about practitioners’ experiences with informed consent. This qualitative study applied the principles of phenomenology and attempted to ascertain how adolescent informed consent was perceived and understood by mental health practitioners. Furthermore, little is also known about how parental consent or informed consent affects adolescent access and use of mental health services. In light of these gaps, the overall purpose of this study was to understand the perceptions of mental health practitioners as it related to adolescent informed consent for outpatient mental health treatment. In order to understand this phenomenon, the following tools were used to collect data: a Screening Guide (see Appendix A), a Demographic Questionnaire (see Appendix B), and a Semi-Structured Interview Guide (see Appendix C).

A Phenomenological Perspective: Interpretive Phenomenology

Phenomenology, this study’s research design, developed as an alternative to scientific methods that had traditionally been used in social science research (Pascal, 2010). The essence of phenomenological studies is the core meanings mutually understood through commonly shared experiences of everyday life (Patton, 2002). Edmund Husserl is considered the founding father of phenomenology. He was concerned with understanding people’s lives and posited that through bracketing (keeping a distance from one’s own subjectivity) it becomes possible to analyze experiences and gain an understanding of the object or situation one experienced (Heidegger, 1996; Moran & Mooney, 2002).
According to Merleau-Ponty (1964), a person’s view of the world is not based on generic, known truths but rather on an understanding of the experiences within the person. A person’s perceptions are based on that individual’s locality in life. For example, when people share similar experiences, it is often assumed that they are beholden to the same perceptions and understandings of those experiences. However, there may be varying perceptions of the experiences that shed light on the person’s locality—emotionally, socially, and mentally. These varying perceptions shape the person’s understanding of his or her experiences, and it is an understanding of these perceptions that allows people to discover their own individual truths, values, and certainties.

In order to gain an in-depth understanding of an individual’s experience, interpretive phenomenology involves questioning, comparing, and imaginatively dwelling in the person’s situation (Benner, 1994; Crist & Tanner, 2003). Interpretive phenomenology aims to study persons, events, and practices on their own terms in order to gain a deeper understanding of their world. The goal of the researcher is to understand the voices of participants and give access to their meanings by presenting the experiences from various interpretive vantage points (Benner, 1994; Crist & Tanner, 2003). From this process, a thematic analysis develops that clarifies distinctions and similarities in the dialogue of practitioners. Exemplars convey the aspects of the thematic analysis and demonstrate the intents and concerns residing within the contexts and situations of the lived experience.

In this case, the exemplars serve to illustrate the characteristics and practices of the phenomenon of informed consent (Benner, 1994). Overall, the study seeks to address the gaps discussed in the literature: namely, the factors that affect adolescent access to mental health care,
with particular attention paid to how mental health practitioners understand and experience adolescent informed consent and its effect on mental health treatment.

**Research Design and Development of Interview Guide**

A qualitative study was designed, beginning with the interview guide. The interview was designed with general questions that facilitated an open dialogue with practitioners in order to explore their understandings of how consent may or may not have affected adolescent access to outpatient mental health treatment. Furthermore, it explored what it meant for a practitioner to obtain informed adolescent or parental consent. In addition, the interview gathered the practitioner’s experience with consent and how this process was perceived by both practitioners and adolescents. The interview also revealed how the process of consent influenced adolescents’ entry into services and retention in treatment. What needed to be determined from the perspective of the practitioner was whether adolescents had the competence to consent to their own mental health treatment. In examining the relationship between mental health practitioners and adolescents, the interview guide afforded the opportunity to explore factors such as the provider’s obligations, considerations that are made with consent and the people who inform policies on consent as well as the adolescent’s response to the treatment process. Furthermore, provider interviews revealed how adolescents are referred to outpatient mental health services (i.e., was it through a parent or caregiver or were the adolescents consenting to their own mental health treatment?). Other relevant data obtained included the way in which adolescents utilized mental health treatment. For example, were they meeting their treatment goals and how long did they remain in treatment? Did mental health treatment differentiate by age, gender, ethnicity,
diagnosis, modality (individual, collateral or family), location of services, or outreach and engagement efforts?

The study of the phenomenon of practitioner perceptions with informed consent required that data be acquired from the field (see Urquhart 2013). For the purpose of this study, a semi-structured interview was used, creating a loose road map regarding inquiry direction and focus. The researcher enters the interview with certain topics in mind but, through the course of the interview, has the space to pursue whatever else may emerge. Through the use of an interview guide, semi-structured interviews increase the comprehensiveness of the data and create a systematic approach to data collection (Patton, 2002). This method is more time consuming than utilizing focus groups. In contrast to conversational interviewing, it has no predetermined questions and is especially useful with ethnographic or fieldwork studies. In addition, the semi-structured interview guide allows the interview process to remain in the form of a conversation, offering a balance between efficiency and discovery (Patton, 2002). This semi-structured approach to interviewing was the best choice for the study of consent because, as the researcher, I was limited to one-time interviews with providers. Therefore, the semi-structured interview ensured a more focused line of inquiry about consent.

In addition, the atmosphere and organization of the clinic settings in which the research respondents were employed would have limited an unstructured interview. The policies of the New York State Office of Mental Health place restrictions on how much researchers can access clinics and client information due to the Health Insurance Portability Accountability Act of 1996 (HIPAA) guidelines concerning patient protection. The HIPAA privacy rule was designed to protect the privacy of individually identifiable health information (U.S. Department of Health and Human Services, n.d.). A semi-structured interview format enabled me to carefully decide
how best to utilize the limited time and limited access. Additionally, the semi-structured interview allowed me to interview providers in a more systematic and comprehensive way by delimiting in advance the phenomenology of consent and by helping me to establish priorities for the interview. Additionally, the interview guide provided me the opportunity to explore, probe, and ask questions that elucidated the issues involved in procuring adolescent informed consent. Finally, this method of inquiry allowed me to be focused and to develop the conversation within this particular area, allowing individual provider perceptions to emerge.

The first stage in the design of this dissertation study was to develop a screening guide with three questions. Within the questions, probes were used to increase the depth of each question. The three questions explored the level of experience a practitioner has in the delivery of mental health services for adolescents, how did the practitioner become involved in the mental health care of this population and the description of their current mental health setting. The screening guide was administered before the interview guide and was used to identify those practitioners who met the criteria necessary to participate in the study. The screening guide identified inclusion and exclusion criteria and set boundaries for respondent participation. The inclusion criteria included screening for participants who had experience providing mental health treatment to adolescents and the exclusion criteria included eliminating those participants who did not have experience rendering care to this population.

Following the screening guide, a socio-demographic questionnaire was administered to participants who met the criteria for participation. The socio-demographic questionnaire identified socio-cultural variables such as gender, race, income, marital and employment status, and level of licensure. The purpose of the socio-demographic questionnaire was used to describe the participant’s background and develop a profile of the respondents.
Licensed social workers practicing in the mental health field were introduced to this study and invited to participate. There were 20 licensed social workers who completed the Screening Guide (see Appendix A), the Demographic Questionnaire (see Appendix B), and the Semi-Structured Interview (see Appendix C).

The semi-structured interview guide was composed of nine general questions whose common thread was an exploration of the nature of consent based on the perspectives and experiences of the providers. Within each question were a series of more relevant questions and probes, and these probes were used to deepen the responses to a question, increase the richness and depth of responses, and give cues to the interviewee about the level of response that was desired (Patton, 2002). Some of the probes explored the consent obligations of the provider working with adolescents. Other probes explored how consent may have affected the delivery of services to adolescents. Final probes focused on understanding adolescents’ response to parents after consent for services had been rendered and the way in which consent influences the therapeutic relationship and the rates of retention and utilization of psychiatric services. All of the probes were detail-oriented and elaborate, thereby cultivating discovery.

Sample and Data Collection

Sample Selection Process

Due to the qualitative nature of the proposed study, a purposeful non-probability sample was used. According to Patton (2002), purposeful sampling offers the researcher the opportunity of selecting information rich cases that afford an in depth study of the main importance of the research. The objective of the proposed study was rooted in an exploration of the phenomenon of consent in a mental health setting; therefore, a purposeful non-probability sampling allowed us
to use a small sample size that kept to the study’s purpose. I interviewed 20 licensed master-level practitioners with no less than 3 years of mental health experience and/or licensed clinical social workers who had at least 3 years of post-master-of-social-work supervised experience in diagnosis, psychotherapy, and assessment-based treatment planning. Additionally, the participants interviewed had experience working with adolescents. According to Padget (2008), purposeful sampling is a deliberate process of selecting respondents based on their ability to provide the needed information. In this case the 20 respondents chosen are licensed social work clinicians with adolescent mental health experience. There were no fixed requirements for sample size in the purposeful non-probability sampling; instead, the sampling strategy was dictated by an opportunity to gather a range of experiences and the richest possible descriptions of the phenomenon being investigated (Patton, 2002). Qualitative studies are concerned with gathering an in-depth understanding of the phenomenon being studied—hence the use of small sample sizes. In this case, a small sample size allowed me to focus on the procedures and rationales involved in adolescent informed consent. Sampling 20 participants enabled me to create categories from the data and then analyze relationships between these categories, while at the same time attending to how the “lived experience” of the participants could be understood (Charmaz, 1990).

Additionally, the use of 20 participants is consistent with other research in healthcare and allowed me to collect data that was of sufficient quality and quantity (Kirchner, Cody, Thrush, Sullivan, & Rapp, 2004; Willging, Salvador, & Kano, 2006). For example, in a qualitative study conducted by Becho and colleagues (2013), 20 participants were also interviewed. In that case, the sample size was also purposeful, and the semi-structured interviews were used to investigate the day-to-day dynamics of husband-to-wife abuse. The report yielded positive results: a further
understanding of resources and support for women in abusive relationships. In a study conducted by Featherstone and Donovan (1998), 20 participants were interviewed to investigate the understanding of randomization in treatment. Once again, the sample was purposeful, and the interviews contained a checklist of topics and narratives. The narratives were used to identify common themes emerging from the participants’ experiences with urinary tract symptoms. The study noted the importance of consistency between the information given to patients and the actual treatment received. As per Charmaz (1990) and Padget (2008), the sample size in all of these qualitative research studies was smaller compared to those in quantitative studies, offering the researchers an opportunity to observe in more detail the phenomenon in question.

Interviewing people of similar backgrounds in mental health about their experiences with informed consent provided a richness and depth that enabled a more in-depth discovery and understanding of the issues that specifically impact informed consent. Purposefully selecting a sample of mental health practitioners with experience working with adolescents was needed to gain the necessary understanding of and information about the phenomenon of consent decree. This sample revealed (1) how practitioners engage adolescents in treatment, (2) how the course of psychotherapeutic treatment evolved, (3) how adolescents come into treatment during the intake and referral process, and (4) how and why adolescents disengage from treatment.

**Demographics of Sample Population**

The sample consisted of eight males and twelve females (see Table 4.1). Both males and females ranged in age from 25 to over age 55. The overall median age of the participants was 36-45. Two of the female and one of the male participants identified as Asian. Four female and
five male participants identified as White. Five female and two male participants identified as Hispanic and only one participant, a female, identified as Black/African American. Seven participants were married and all seven were female. One male participant was divorced, four male participants were partnered, and one female participant was partnered. Three males and four females were single. Of the participants, 16 were licensed clinical social workers (LCSW) and four of the participants were licensed master-level social workers (LMSW). All participants were employed minus one female respondent who was retired. In terms of income, one female participant reported an income of $20,000 or less, and another reported an income of between $21,000 and $35,000. Two other female and one male respondent reported an income of $36,000 to $50,000. Five female and two male respondents reported an income between $51,000 and $65,000. Eight participants reported an income over $66,000, three of whom were females and five male. Among the participants, the median income was $65,000.

**Data Collection Procedures**

As noted earlier, the three major sources of data collection tools were the Screening Guide (Appendix A), the Demographic Questionnaire (Appendix B), and the Semi-Structured Interview Guide (Appendix C). The Screening Guide enabled me to recruit 20 people who had clinical experience in mental health settings and the psychosocial treatment of adolescents. After meeting the inclusion criteria for participation in this study, the respondents who voluntarily agreed to participate in this study completed consent forms. After the consent forms were signed, the Demographic Questionnaire was administered to all 20 participants. The Questionnaire took less than three minutes to complete and provided the means for a basic demographic profile of respondents (see Table 4.1).
The Semi-Structured Interview followed the demographic questionnaire and it served to capture and describe mental health practitioners’ understandings of and experience with adolescent informed consent in mental health settings. The 20 semi-structured interviews lasted approximately 90 minutes each. Interviews were conducted over an eight-month period. With the participants’ consent, I audiotaped each interview and hired a transcriber to review the audio recordings and provide typewritten transcripts of the interviews for data analysis. The interviews were securely stored in a locked file cabinet, and a de-identifying process was used to conduct data collection. For example, participant names were removed from the interviews and a number assigned to each interview to protect their identity. Throughout the interview process, I also took field notes by recording my impressions and observations of the participants as they described their experiences with adolescent informed consent. The goal was to familiarize myself with the transcripts and gain an overall impression of the content. To that end, I read and reread the interviews to gain an in-depth understanding of how practitioners understand the phenomenon of adolescent informed consent, specifically how consent may or may not have affected adolescent engagement in mental health treatment and how providers understood the process of obtaining consent.

The use of the Semi-Structured Interview Guide (see Appendix A) provided an opportunity for mental health practitioners to share their direct experiences specific to the phenomenon of consent. The guide also served the purpose of providing direction and a focus for each interview. I designed the questions with the intent to gather information specific to the participants’ experiences with and understanding of adolescent informed consent. I interviewed participants who had experience in providing adolescent mental health services at diverse mental health settings. Many of the participants I interviewed revealed that it was important for them to
share their experience with adolescent informed consent. The participants seemed relieved that someone was listening to and recording their stories. They also shared the hope that the outcomes of this study would shed light on the importance of practitioners’ understanding of consent and its implications for practice in mental health clinics.

In securing a sample population, I reached out to former colleagues who had experience providing clinical services to adolescents in mental health clinics. Doing so afforded me the opportunity to enter this process with them, and it also provided them with the space to pursue salient themes that emerged during the interviews. Due to New York State Office of Mental Health (NYS OMH) policies and the restrictions placed on how much access researchers have to clinics and client information, most practitioners opted to meet with me in a non-clinical setting. Consequently, there was a sense of ease as they shared their in-depth experiences without reservation.

**Data Analysis**

The data collected from the interviews via audio recorder were transcribed, and all participants’ identifying information was de-coded and de-identified to protect confidentiality. As recommended by Miles and Huberman (1994), my first effort in managing the data involved completing a content analysis of the transcripts. By reviewing each of the 20 interviews and systematically listing the individual responses to the questions elicited from the interview guide, I was able to organize the feedback in a comprehensive way while noting the variations in how practitioners understood the informed consent process.

I then proceeded to “bracket” the responses into units of meaning. According to Ahern (1999), bracketing is a means of demonstrating the validity of the data collection and analysis
process while accurately describing the participants’ life experience. Hycner (1985) and Starks and Trinidad (2007) noted that phenomenological analysis requires an effort to open ourselves to the phenomenon under study. After bracketing the responses, I delineated the units of meaning. Units of meaning are defined as words or phrases that determine whether what the participant has said responds to the research questions (see Hycner 1985). The responses in the interviews were categorized according to their corresponding questions. The data collected generated 112 units of meaning. Hays and Singh (2012) described units of meaning as distinct expressions in the words of the participants relevant to the study. This step helped me to analyze the data in a way that was more manageable and efficient within the context of the interviews. I proceeded to cluster the units of meaning into common themes and relationships which were relevant to the study. This process is known as horizontalization within phenomenological studies (Hays & Singh, 2012).

During this initial stage of data analysis, I examined the interviews for common themes concerning the phenomenon of consent by sorting and sifting through the data and listing each statement that would lead to understanding the meaning and essence of practitioners’ experiences with adolescent consent. The initial 112 units of meaning were eventually reduced to 108 units of meaning relevant to the following research questions: (1) How do practitioners understand adolescent informed consent? (2) How does informed consent affect adolescent access to mental health treatment and utilization of services as perceived by practitioners? (3) How do practitioners understand and describe the impact informed consent has on adolescent engagement in mental health treatment? (4) How do practitioners experience the ramifications of informed consent in building a therapeutic relationship with adolescents? From these research questions, general themes and topics were generated concerning policies, consent, work settings, mental
health utilization, and delivery of mental health services. According to Hycner (1985), organizing the units of relevant meaning to try and see if they naturally cluster together into more specific common themes may contribute to the goals of the study.

Selecting subcategories for the unit of meanings enabled specific themes to emerge. For example, each of the four study questions that were coded into units of meaning had subcategories. The first study question (How do practitioners understand adolescent informed consent?) had three subcategories: practitioners’ policies, responsibilities, and understandings of the mental health laws regarding adolescent informed consent. The second study question (How does informed consent affect adolescent access to mental health treatment and utilization of services as perceived by practitioners?) had four subcategories: whether practitioners obtained parental consent, how adolescents were admitted into mental health services, how informed consent affected service delivery, and how adolescents utilized mental health treatment. The third study question (How do practitioners understand and describe the impact informed consent has on adolescent engagement in mental health treatment?) had three subcategories: the way in which providers engage adolescents in mental health treatment, the adolescents’ responses to treatment services, and whether there was resistance to treatment when there was parental consent versus adolescent informed consent. The last study question (How do practitioners experience the ramifications of informed consent in building a therapeutic relationship with adolescents?) had four subcategories: whether parents wanted information about their adolescent’s treatment, how parental and adolescent informed consent affected the therapeutic relationship with the provider, whether adolescents dropped out of treatment after obtaining parental consent versus adolescent informed consent, and whether the adolescents remained in treatment if they consented on their own. According to Padgett (2008), saturation does not
depend on the frequency of responses but rather on their depth. Furthermore, it is the point in the data collection where no new or relevant information emerges within the study. By the fifth interview, I began to reach saturation for these subcategories.

As the phenomenological data analysis developed, it allowed me to discover dimensions within the research questions. From the selective clustering process, relationships and central themes emerged. Hycner (1985) and Hays and Singh (2012) described this selective clustering process as structural description: where relationships are identified and an understanding of the complexity among the relationships is sought. From this process, certain common themes emerged. I read the transcripts a fourth time, and by the time I reached the 10th interview, saturation had been reached. At the point of the 10th interview, no additional data collection emerged, no new codes were developed, and the themes were fleshed out. The most substantiated themes were included in the analysis, which resulted in the collapsing of units, yielding 63 clusters of meaning from the previous 108. From a phenomenological standpoint, developing units and clusters of meaning provided a clear way of understanding the themes concerning providers’ experiences with adolescent informed consent. After reading each transcript over again, I considered the research questions in order to further analyze the data. For example, the unit of meaning such as “barriers,” supported the theme “Resistance.” Another example consisted of the unit of meaning, “I can talk to you,” supported the theme, “Trust.” From a phenomenological approach, developing units and clusters of meaning provided me with a clear way of understanding the themes about how providers experience adolescent informed consent. At the reading of each of the transcripts, I considered the research questions, clinical understanding of informed consent, and analysis of the data.
The common themes were correlated to each other and exemplars emerged. In interpretive phenomenology, exemplars operationalize the common themes into similar or contrasting patterns that established a field of relationships correlated to the research questions (Benner, 1994). For example, the themes, “Intakes,” “Policies,” “Regulations,” and “Consent,” were correlated as related to how practitioners understood informed consent. As a result, they were reduced to the exemplar, “Practitioners’ Knowledge of Informed Consent.” The exemplars were reduced to the overarching concepts captured by the four study questions and their common themes.

After the descriptions of categories were complete and the interviews were fully analyzed, I tabulated the overall responses for each category. It was important to also account for outlier responses that were not included within the categories. I concluded that the analysis was complete when no new revisions were necessary. I used this phenomenological method of analysis to organize the presentation of findings that are reported in Chapter IV.

Protection of Human Subjects

Approval from the Institutional Review Board (IRB) through the Silberman School of Social Work at Hunter College of the City University of New York was required (see Appendix E). The purpose of the IRB is to protect the integrity of research with human subjects. Each participant consented by voluntarily signing a consent form to participate in one interview that asked participants about the nature of their experiences in mental health settings, their experiences working with adolescents, and their experiences with obtaining informed consent (see Appendix D). The time commitment of each participant was approximately 90 minutes. Each session took place at the Silberman School of Social Work at Hunter College. Participants
were informed of the risks and benefits of the study and were also notified of possible breaches of confidentiality. To minimize these risks, all participants were informed about the voluntary nature of participation in the study and the manner in which privacy was assured. While there were no direct benefits, participants were informed that participation in the study may increase general awareness of adolescent treatment practices and their consequences for mental health.

Once consent was obtained, the data was collected in writing and was only accessible to this writer in order to protect against breaches of confidentiality. The confidentiality and privacy of participants was protected by coding and encrypting any identifying information such as names. Confidentiality was achieved by storing the data in a secure, locked cabinet. After the study is completed, the data will be retained in a locked and secured cabinet for a period of at least three years after the research has been discontinued. After that time period, the original data will be destroyed.
Chapter IV: Findings

Introduction

The purpose of this study was to examine mental health practitioners’ understanding of adolescent informed consent and the impact that it has on the delivery of mental health services. I interviewed participants who are either licensed master-level social workers or licensed clinical social workers in New York State. I examined the data collected from the interviews employing a phenomenological approach. A semi-structured interview guide was used to facilitate conversations with practitioners.

This chapter will report the findings of a qualitative analysis of the interviews with 20 mental health practitioners. The findings describe what practitioners know and understand about informed consent regarding adolescent mental health treatment and how consent may act as a facilitator or barrier to adolescents seeking mental health services. I begin with a discussion of the interview guide, how it was used, and the responses that were elicited. Additionally, this chapter presents a brief demographic description of the participants and their experience working in mental health settings with adolescents. Finally, this chapter will also delve into five exemplars which emerged out of the research questions and the practitioner’s experience which characterize the common themes. The themes and the exemplars offer a balance between breadth and depth of exploration regarding the phenomenon of consent.

Research Questions and Exemplars

This study sought to answer the following research questions: (1) How do practitioners understand adolescent informed consent? (2) How does informed consent affect adolescent access to mental health treatment and utilization of services as perceived by practitioners? (3) How do practitioners understand and describe the impact informed consent has on adolescent
engagement in mental health treatment? (4) How do practitioners experience the impact of informed consent in building a therapeutic relationship with adolescents? Out of these research questions, four exemplars emerged: (1) practitioner’s knowledge of informed consent, (2) practitioner’s response to consent, (3) treatment consequences of consent, and (4) practitioner experiences with consent. These exemplars are clear, identified patterns, which are meant to operationalize the themes that emerged. Exemplars are salient excerpts from the practitioner’s experience that distinguish common themes or meanings and answer the research questions. They also establish categories of meaning that can continue to be expanded upon and refined as an understanding of the phenomenon deepens (Benner, 1994; Crist & Tanner, 2003). These exemplars will capture the essence of the practitioner’s lived experience with the phenomenon of consent. They do not suggest only a single way of experiencing consent; instead, there were several themes that emerged from the experience of the practitioners.

Themes

Interpretive phenomenology incorporates the use of themes to clarify commonalities and differences (Benner, 1994). The themes emerge out of meaningful patterns or core concerns arising from the ways in which these practitioners experience adolescent informed consent. The following core themes emerged in this dissertation study: intakes, policies, regulations, consent, confidentiality, resistance, trust, frustration, and parental involvement. These themes reflect the practitioners’ experiences (both positive and negative) with adolescent informed consent, their day-to-day experiences shedding more light on the consent phenomenon (Benner, 1994; Crist & Tanner, 2003). The themes also reflect the commonalities and differences practitioners shared with respect to informed consent. As part of their understanding of informed consent, practitioners experienced how informed consent affects treatment, how they themselves respond
to consent practices, and how consent practices make them feel. These themes address the lived experiences of practitioners and the challenges that they face when providing mental health treatment to adolescents.
Figure 4.1: Synthesis of Findings
Demographic Background of Study Participants

The participants consisted of eight English-speaking males and 12 English-speaking females (see Table 4.1), all of whom are described in greater detail below. The participants have been de-identified to protect their anonymity. Specific ages were not identified; instead, a range of ages was used to describe the sample. The oldest male was 55 or over and the youngest male was between 25-35. The ages of the females participants ranged from 25-35 and the only oldest female was 55 or over. Of the participants, 16 were licensed clinical social workers and four of the participants were licensed as master-level social workers. All were employed at the time of the study (with the exception of one female participant who was retired). All of the participants reported working with marginalized adolescents who had long histories of social problems and who resided in poor urban communities. The participants also reported contending with a range of social and environmental factors that have influenced how adolescents access care. From a reciprocal perspective, the way in which adolescents seek care has influenced how practitioners render mental health services.
Table 4.1

Socio-Demographic Profile

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Race/Ethnicity</th>
<th>Marital Status</th>
<th>Level of Licensure</th>
<th>Employment Status</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>Over 55</td>
<td>White</td>
<td>Single</td>
<td>LCSW</td>
<td>Employed</td>
<td>Over $66,000</td>
</tr>
<tr>
<td>2</td>
<td>Male</td>
<td>36-45</td>
<td>White</td>
<td>Partnered</td>
<td>LCSW</td>
<td>Employed</td>
<td>Over $66,000</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>25-35</td>
<td>White</td>
<td>Married</td>
<td>LMSW</td>
<td>Employed</td>
<td>$21,000-$35,000</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>25-35</td>
<td>Asian</td>
<td>Married</td>
<td>LMSW</td>
<td>Employed</td>
<td>$36,000-$50,000</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>36-45</td>
<td>Asian</td>
<td>Single</td>
<td>LCSW</td>
<td>Employed</td>
<td>$51,000-$65,000</td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
<td>Over 55</td>
<td>Hispanic</td>
<td>Partnered</td>
<td>LCSW</td>
<td>Retired</td>
<td>$20,000 or Under</td>
</tr>
<tr>
<td>7</td>
<td>Female</td>
<td>36-45</td>
<td>Black</td>
<td>Single</td>
<td>LCSW</td>
<td>Employed</td>
<td>$36,000-$50,000</td>
</tr>
<tr>
<td>8</td>
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Keith, who is 55 years of age or older, has been a practicing clinician and administrator for more than 35 years. Keith has worked in diverse mental health settings, including both for-profit and not-for-profit hospitals and community-based programs. He has also worked with diverse populations and age groups. Keith has always enjoyed mentoring and shaping young clinicians, has made significant supervisory contributions, and continuously seeks to advocate on behalf of disenfranchised groups. Finally, he continues to be involved with the Coalition of Behavioral Health Agencies and is an outspoken voice for the mentally ill.

Rachel is a licensed master social worker in her late 20s and has worked in community-based mental health clinics and school-based clinics for more than 3 years. She has primarily worked with children and adolescents and reported that she prefers to see adolescents in school-based settings because they are more accessible and more engaged by mental health treatment; she can go directly to their classrooms, and they in turn can see her with minimal involvement from adults.

John is in his mid-30s. He is a trained psychoanalyst and usually uses his analytic orientation in his work with his clients. He has worked with diverse populations in community settings and in institutional programs. John also has a private practice and teaches psychoanalysis at various institutions for clinicians interested in psychoanalytic training. John has worked in disenfranchised communities and has often shared his experiences as a White male in his work with youths of color, with his colleagues, and with me.

Winnie is an Asian female in her late 20s. She is a licensed master social worker and works as a program director for a home-based crisis program on the Lower East Side of Manhattan. Winnie has experience working with children and adolescents from a number of cultures. She provides mental health services both in the community and in her client’s homes.
Although she was raised by conservative Asian parents, Winnie incorporates acculturation methods into her work with American-born adolescents who struggle with balancing Asian tradition and American values.

Henry is an Asian male in his late 30s who has a background as a middle school teacher and who left teaching to pursue a career as a clinical social worker. He has primarily worked with Black, Latino, and Asian youth in disenfranchised communities. Henry is interested in policy and how it has influenced his clinical work and shaped his decisions regarding access to mental health services for populations in need.

Fanny is a seasoned licensed clinical social worker over the age of 55 who began her career in grassroots organizations. She began practicing in the late 1960s and identifies herself as “old school social worker.” When asked what this meant, she reported, “I was always in the community meeting people where they were at—the park bench or in their homes.” She identifies as Latina and is proud to serve the Latino community. She has worked with diverse age groups and has provided a range of clinical and case management services.

Cindy is an African American female who is a licensed clinical social worker. She has been a social worker for more than 8 years and has a background working with children and adolescents in community-based and school-based programs. She has recently worked for a youth development organization where she rendered clinical services to marginalized adolescents who had experienced addiction and homelessness. She believes that the majority of the problems she has encountered center on family dynamics, which result in adolescents being removed from their homes, being involved with multiple social agencies (including foster care), and experimenting with various substances.
Renee has been a practicing licensed clinical social worker for more than 15 years. He is a Latino male in his early 40’s. Renee has experience working with diverse communities and populations. He is based in Washington Heights in Manhattan and has experienced the challenges his clients face due to poverty and other social problems imbedded in the community. Due to these challenges, Renee sought to establish a small community-based program where he reports feeling the freedom to offer clinical services that are accessible and devoid of bureaucracy.

Denis is a White male in his mid-40s who is a licensed clinical social worker. He is presently pursuing his doctoral degree in social work and has experience working with diverse ethnic groups as both a clinician and administrator. Denis is currently working at a youth development agency where he collaborates with diverse agencies to assist youth who are homeless or using substances or who have histories of incarceration or other social problems. Denis believes in incorporating family dynamics into his work with adolescents and encourages his staff to follow policy guidelines in their work with youths.

Rosie is a licensed clinical social worker in her mid-30s. She is a Latina female who has worked in various grass-roots and community-based organizations in California, New York City, and Mexico. Rosie has worked with diverse age groups and ethnic groups and reports, “My heart belongs with the Latino youth and communities I have served.” She presently provides confidential comprehensive medical and mental health services at a clinic for adolescents in Washington Heights.

Jaime is a Latino male in his late 20s who is a licensed clinical social worker practicing at a school-based mental health clinic. He has experience working in youth development programs, mental health clinics, and school-based programs. Jaime has worked with disenfranchised youth
of color and has also worked with LGTBQ (lesbian, gay, transgender, bisexual, and questioning) adolescents. He reports challenges with working with the LGTBQ population given that practitioners follow agency policy to protect their privacy yet many of their parents want information regarding the adolescents who receive LGTBQ services. Jamie currently provides clinical services to both LGTBQ and non-LGTBQ adolescents.

Mickey is a Latina female in her late 30s who is a licensed clinical social worker. She has worked in diverse communities and with diverse ethnic groups, providing mental health services in medical and mental health clinics. Mickey reports incorporating families in her work with adolescents to facilitate communication and to improve utilization.

Jerry is a White male in his late 30s who is a licensed master social worker. Jerry spent many years working with homeless and runaway youth in different social services organizations. Jerry reports working extensively with the criminal justice system, homeless services, and the child welfare system. He is currently working at both a mental health clinic and a youth development program and reports stark differences in how each program grants access to health and mental health services. Part of his role with the adolescents he treats includes helping them negotiate the systems they are involved with, while at the same time empowering adolescents to live healthier lives.

Helen is a White female in her mid-40s and is both a licensed clinical social worker and a licensed clinical art therapist. She has provided both adult and adolescent mental health services in diverse settings, including health, mental health, and school-based clinics. Helen has worked with adolescents with at-risk behaviors, has provided reproductive health counseling, and has worked with adolescents who have very little family support. She dedicates herself to empowering adolescents to make appropriate decisions regarding their academics and their
health and mental health needs and supports policies that would enable adolescent access to mental health services without parental consent.

Yesenia is a Latina female in her late 30s and has been a practicing licensed clinical social worker for 15 years. She has worked with diverse ethnic groups and populations. Yesenia has also worked with adults and families who experienced trauma due to the World Trade Center attack in 2001. Her expertise in trauma treatment has enabled her to support and help adolescents who have been victims of abuse and maltreatment. Yesenia prefers to work with Latino and immigrant families who are economically and socially marginalized.

James is a White male in his late 30s who is a licensed clinical social worker with 18 years of experience in direct practice and management. He is presently a doctoral candidate in social work and a clinic administrator at a multi-service agency that specializes in LGBTQ and HIV issues. James has also worked with diverse age groups in various mental health clinics and in school-based programs. In his current practice, James has the flexibility of providing confidential and private mental and medical health services to adolescents and has had the opportunity to extend mental health services to adolescents in lower Manhattan.

Jenna is a White female in her late 30s who is a licensed clinical social worker. She has a background in clinical and substance addiction services. Jenna has provided vocational, case management, mental health, and harm reduction services to at-risk youth. She has collaborated with adolescent shelter services, the juvenile justice system, school-based mental health clinics, reproductive health centers, youth development programs, and mental health clinics. Additionally, Jenna was also the director of a community outreach van service that was funded by a youth development organization. The van would drive throughout Manhattan and the Bronx to provide social services to homeless youths under 21. Most of the adolescents she has
worked with have minimal parental support, which has had a profound, traumatic effect on the adolescents she serves.

Vivian is an Asian female in her late 30s who is a licensed clinical social worker with experience working with poor Asian and immigrant families in Lower Manhattan. She renders mental health services in mental health clinics and school-based mental health programs. Vivian reports challenges with obtaining parental support and attributes these challenges to social problems plaguing the adolescents she has worked with as well as parental consent policies. Many of the adolescents she has treated have experienced trauma, abuse, and neglect. The school-based mental health clinic provides a protective hub for these adolescents and facilitates access to mental health treatment.

Kailey is a Latina female in her early 30s. She is a licensed clinical social worker and is currently providing mental health services at a youth development organization with a diverse ethnic population including LGBTQ youth, homeless youth, and adolescents involved in the child welfare system. She has had experience providing mental health services at community-based mental health programs in disenfranchised Queens’s neighborhoods. Kailey reports that even though her current adolescent population faces many social problems, she finds these adolescents easier to work with because there has been no involvement by parents or families. She focuses on helping adolescents gain access to social and mental health services while empowering them to live independent lives.

Brenda is a White female in her early 40s who is a licensed clinical social worker. She is currently a clinic administrator in a major New York City hospital. The clinic is one of the largest child and adolescent mental health providers and provides a wide range of clinical services, including case management, therapeutic nursery services, and school-based medical
and mental health services in Manhattan, Brooklyn, and the Bronx. Brenda supports adolescents who seek mental health services without parental involvement; however, due to statewide policies and hospital protocols, the clinic and its community programs engage parents in the provision of adolescent mental health treatment.

The participants in this dissertation study were licensed master and clinical social workers who have provided services to adolescents in various disenfranchised communities. They have worked with different social agencies to support adolescents and provide mental health services to those who have histories with child welfare agencies, youth development organizations, the juvenile justice system, and/or medical and mental health clinics. Many of the study participants have also worked with racially and ethnically diverse adolescents who have marginal family and parental support. A number of participants have also rendered services to adolescents who identify as LGBTQ, who are homeless, or who engage in at-risk behaviors including substance use.

Exemplars

Practitioners’ Knowledge of Informed Consent

The exemplar Practitioners’ knowledge of informed consent, describes and answers the following research question: “How do practitioners understand adolescent informed consent?” Practitioners’ knowledge and understanding of informed consent stem from their experience with state regulations and clinic policies. The themes that emerge from this exemplar include “regulations,” “policies,” “consent,” and “intakes.” These themes specifically address the concerns and experiences practitioners shared regarding their understanding of informed consent.
Most social work practitioners turn to the New York State Office of Mental Health (NYS OMH) for guidance regarding mental health practices with clients. Practitioners consequently follow NYS OMH guidelines and regulations for the provision of mental health services, and these regulations and guidelines are interpreted by clinic leadership and are explained to practitioners in the form of clinic policies. Some participants reported that there may in turn be different interpretations of NYS OMH guidelines at different clinics. The findings revealed that practitioners will adhere to these clinical guidelines regardless of their own interests. What emerged is each practitioner’s description of how he or she contends with the organization of policies, rules, and regulations concerning informed consent and how he or she balances the obligation to adhere to these guidelines with the obligation to the adolescents themselves.

**Regulations**

As a theme, “regulations” refers to sets of guidelines prescribed by the New York State Office of Mental Health (NYS OMH) and are designed to ensure that there is adherence to the parameters of clinical practice (NYS OMH, 2009). What follows is the practitioners’ experience and rendition of how these regulations are passed down to them and inform their practice. Some practitioners also viewed the regulations as a form of protection while others simply stated they followed what the regulations impose.

Jamie, who has experience working in youth development programs, mental health clinics, and school-based services, reports relying on the agency to interpret the policies from the NYS OMH and to disseminate these policy interpretations to its practitioners and clinics. In his practice with clients, Jamie experienced the regulations as a benefit (i.e., the regulations were a form of protection). This protection served to inform him about how to work with the different types of clients he came in contact with in his practice:
Every agency abides by different regulations, different guidelines, because of whom they service and what the services are. The regulations were interpreted through NYS OMH regulations, and they varied from agency to agency. I don’t think the agencies were really in essence trying to find loopholes. It wasn’t about that. I think it was more about how do we best serve and protect the clients that we’re working with. Based on what I said before, I’m working with varied populations and such varied organizational agencies; because of that, I think there were different ways of interpreting the regulations. So, yeah, I’m pretty sure they were going by NYS OMH regulations.

For Jamie, these interpretations removed some of the guesswork that might otherwise have been involved.

Cindy reports that the clinic and school-based mental health clinics where she has provided mental health services are also governed by the NYS OMH. Under this governance, Cindy explains that she follows the regulations as set forth by her supervisors:

Basically, since the clinic is governed by the NYS OMH, we have to adhere to OMH regulations regarding consent for young people under the age of 18. I’m informed by the clinic director and by the assistant director when the intake policy is explained to me for young people under the age of 18. The supervisor staff explained the policies.

Cindy reports that she follows OMH regulations as dictated by her clinic leadership, and she believes that these policies are intended to help practitioners understand clinic rules for providing mental health treatment to adolescent clients.

Keith underscores the importance of following regulations regarding consent regardless of his own experience as a practitioner and clinic administrator. As a consequence, he will always obtain parental consent for adolescents under the age of 18 because this is what is dictated to him by the clinic. He also notes the there are many guidelines from the state, the city, and the agency itself that dictate how services should be provided; however, regardless of state and city guidelines, he notes that clinic policies are to be followed for treatment services:
You know, we have all these guidelines: state guidelines, city guidelines, and agency guidelines. These determine the parameters in which we’re going to work with families. That was already established and we just had to sort of follow whatever those regulations were. The clinic had policies with the direct services of mental health and had their policies in terms of the running of the day-to-day operations. The clinic informed us that anyone under the age of 18 who was not emancipated is under the jurisdiction of the parents. So that’s the law.

In this case, clinic policies were clearly aligned with those determined by the state, obviating any conflict between the two.

**Policies**

The theme “policies,” refers to the way in which the regulations set forth by the NYS OMH are interpreted by a clinic’s leadership and implemented in clinical practice by its practitioners. For example, the NYS OMH does not specifically oversee the informed consent process for adolescents seeking mental health. Instead, policies regarding informed consent for adolescents remain within the discretion and practice of the clinic. Therefore, practitioners will normally adhere to the practices of the clinics (See Hickey, 2007; Schachter et al., 2005; Tan et al., 2007).

Denis, a program administrator, oversees different programs in the organization for which he works. These programs are licensed by different state regulatory bodies that dictate how the programs should operate. He noted that policies regarding adolescent consent for mental health treatment are informed by the NYS OMH, which determine that adolescents accessing preventative medical care can do so at the age of 12. However, adolescents seeking mental health treatment can do so only if there is parental consent:

We have different program at our agency. We have a health component, which is licensed by the State of New York as an Article 28. We have a legal component. We have a job-training component. We have a GED component, which is licensed by the State of New York. We have an arts and recreation. And we also have a counseling department. Our
counseling department has two components. We have a component that we operate internally, which is just basic counseling support to adolescents, and then we are also a satellite clinic. A satellite Article 31 location from our parent organization, who is the main carrier of the license for the Article 31. The State of New York, which oversees the New York State Office of Mental Health, has issued mandates on the age of consent and what young people can consent to. So, for instance, young people who require mental health care require parental consent up to the age of 18. For young people in our health center, which is an Article 28, the young people are able to access preventative care at the age of 12 in the State of New York. But for the most part, parental consent is required for mental health conditions for adolescents seeking services at our mental health clinic which is an Article 31.

This disparity in services consequently leads to the provision of services for some adolescents (e.g., those seeking health services) but not for others (e.g., those seeking mental health care).

Jerry, who has experience providing mental health services and social services to a diverse group of adolescents, reports that policies and regulations in the mental health clinic are also dictated by the NYS OMH; however, he is unsure how these policies and regulations are then disseminated to the clinics. He trusts the clinic to act in the best interests of clients receiving mental health treatment:

My understanding of who dictates policies is the following, and I could be wrong: OMH and administration. I think administration obviously has to comply with whatever consent is required through OMH. I certainly don’t have anything to do with determining those policies, I just follow the rules. My understanding is that OMH licenses us to provide these mental health services. In order to do that, we have to be compliant with policies. I actually don’t know how policy makers are selected to work for OMH. I don’t have any information on any of that, so I’m fairly naïve to the entire process. My understanding is only professional, like you come into a job; you know that the agency you’re working for is OMH compliant. You know why it’s OMH compliant, and you do what you have to do.
Jerry and Denis both assume that the NYS OMH is the state organization informing clinical practices. Neither they nor the other practitioners reported questioning these state regulations (which are subsequently translated into clinic policies). Therefore, they follow what is dictated to them and provide mental health services based on the individual clinic’s interpretation of these policies.

Keith, who has experience as a practitioner and administrator, reports that—despite his vast experience and knowledge developing and implementing policies—as a direct practitioner, his responsibility is always to follow clinic policies when engaging adolescents in treatment:

I have been an administrator, I’ve been a clinic director, and I’ve also written and developed many of the policies and procedures for an Article 31 and an Article 16. I will always follow the policies and procedures of the clinic. In the current setting, I would think…adolescents who are under the age of 18 under certain circumstances could provide consent. But normally if they have a parent or caregiver, basically the parent or caregiver must consent for treatment.

Once again, the policy of the clinic seems to take precedence over other considerations in the case of adolescent informed consent.

Yesenia, who has worked with diverse age groups and ethnic populations, reports that she also follows policies of the agency or clinic. According to her, these policies as dictated by clinical leadership and disseminated to practitioners help her to provide the parameters necessary for her clinical work with her clients, particularly with adolescents. Furthermore, she presents these policies to adolescents in an active process to engage them in mental health treatment and informs the adolescents of the necessity of parental involvement in their mental health care:

The agency, my supervisor, director of the clinic, colleagues we reviewed clinic policies, that’s kind of the way to go. This is what we should do, this is a client, this is what we do usually, and we follow clinic policies. We will sit with the client. It will be reinforced by the clinic. I then try to be creative on how to fulfill the clinic rules at the same time. Satisfy the needs of the clients because the age of the
teenager as well and the personality, I think I will accommodate the way that I deliver that information. Sometimes, as a first session, I will have them present and try to engage and develop my connection with the teenager while at the same time saying that everything is authorized by your parents based on clinic policies and they will have the information. They will have the active right to access your information.

Yesenia reported that there is a consensus among the clinic staff (including administrators) that these policies must be followed. She proceeded by indicating that she makes an effort to explain these policies to both adolescents and their parents. In her work with adolescents, Yesenia uses didactic therapeutic techniques to help adolescents understand the clinic’s policies regarding their treatment, including policies concerning parental consent and involvement.

**Consent**

The theme “consent,” refers to the willing acceptance of a specified treatment by a person after adequate disclosure by the practitioner of the nature of the treatment, its risks and benefits, and the consequences of refusing or accepting treatment voluntarily and freely (Bello, 2010; Schmidt and Repucci, 2002; Scott et al., 1995). Practitioners implied that they obtain consent from a parent before they become involved with the adolescent. In addition, practitioners also inform the parent of the nature of treatment as recommended by the NYS OMH and incorporated into clinic policies.

John, who has worked in diverse community settings and has his own private practice, refers to his understanding of parental consent with adolescent mental health treatment as stemming from his academic instruction as a graduate student in a school of social work. He reports that he obtains parental consent for adolescents under age 18, and when adolescents are of age, John obtains their legal consent. John states that this is the procedure which he was taught and trained in:
I was taught in social work school that when you’re working with a child, when you are working with an adolescent, it is actually the parents who are the clients because they are the ones offering the consent. Even though you’re working with the child or adolescent, you’re really beholden to the parent. I’ve heard talk about informed consent and adolescents being able to be informed and consent to their own treatment, but as to the legalities of it, I don’t actually know much. I’ve always had parental involvement when it was anybody under the age of 18. But after 18, this is somebody who I would not still consider an adolescent and they would be able to assign their own consent. When they turn 18, the records would be changed because they are an adult. We would have all new consents signed because now they were able to give legal consent.

For John, this is not only a matter of policy but one of training and practice.

Rachel refers to obtaining parental consent as dictated to her by clinical supervisors and, like John, her academic instruction in a school of social work. She will obtain parental consent, and after parental consent is obtained, she will meet with the adolescent to begin mental health treatment:

I have always been told that anyone under the age of 18 cannot consent for mental health treatment on their own, without their parents. It was told to me in school and what I was told by my supervisors. I’ve never looked into the law myself to find keys to x, y, z, or anything like that. Actually, I didn’t even know that there was a NYS Law about it. So this is the first time I hear it. I’m going to have to look that up. Typically, the parent is the one that initially wants their son or daughter in treatment. Then we make the appointment. We ask the parent to come in at the first session. We want to get some background information about what the parent is reporting, then we meet with the adolescent.

Rachel has based her practice entirely on the training she received. She is unaware that these practices and policies are based on specific New York State law.

Jaime notes that the NYS OMH recommends that in order to provide mental health services to adolescents, parental consent must be obtained. Additionally, he stated that, per New York State’s Minor’s Mental Health Law, parental consent is required if private insurance will be used to pay for mental health care. Practitioners assumed that New York State’s Minor’s
Mental Health Law also requires parental consent when using insurance for mental health services:

I feel like my understanding of the mental health law comes from the different agencies that I’ve worked at. I think for the most part that in order for young people to receive services there needs to be some kind of caregiver consent, whoever the person is who has guardianship of the young person. We’re working at an agency where we are serving young people at the clinic. I think the consent is needed. The young people need it to—it’s an insurance-based agency and I’m pretty sure that New York State has requirements that stipulate that if it’s going to be an insurance-based intervention, then we need the person who manages that and that is usually the caregiver.

Like the others, Jaime has based his practices on training rather than on a full understanding of the laws governing these practices in New York.

Winnie, who has worked in mental health clinics and a home-based crisis program, reports that she always obtains parental consent as dictated by policies before beginning mental health treatment with an adolescent. She stated that in some instances obtaining parental consent has been helpful to the adolescent and to her clinical work with the adolescent:

We need to get the parental consent before we can do anything for the client in terms of, you know, meeting with them and continuing to even ask questions about like how did you end up in the hospital and what can I do for you, that kind of stuff. Even basic stuff we cannot really do without the parental consent. Yes, it’s only the parent or legal guardian who can sign the consent. Parental consent can be beneficial because the client, which is the adolescent, may not see the serious condition at the time, but the parent identified it. The parent consents to the treatment for the adolescent so that will be really beneficial for the adolescent.

Winnie provided an example of a parent who requested services for an adolescent. She explained that, in her work with the adolescent, he did not feel as though he had any problems. However, her clinical opinion was that he did, and she proceeded to obtain parental consent in order to provide mental health services to the adolescent:
Sam (pseudonym for the adolescent) is 15 years old. He doesn’t feel has any problems, but clearly he does. And the parent, which is the mom, strongly requested him to come to treatment, and mom consented for the treatment. And there was some type of connection, I was able to make with him and I check with him weekly to make sure he is stabilized. He is not in the risk of being hospitalized or any other serious problems.

Henry indicates that he will always obtain parental consent. As a practitioner, he openly and adamantly reports that parents are responsible for their adolescent children and their treatment. Furthermore, he will obtain parental consent before an adolescent can begin mental health treatment because it is his understanding of clinic policy:

Me personally, I always see the parent. The parent is always present for the intake appointments and that kind of thing. Maybe not always in the session but always with the intake appointment to get consent for treatment. My responsibility is to obtain parental consent because, ultimately, except for 18-year-olds, I am supposed to. From what I understand about the clinic policies, ultimately the parent is responsible.

Rosie, who has practiced at mental health clinics and school-based mental health clinic, reports that she will obtain parental consent at both the community mental health clinic and the school-based mental health clinic in which she is employed. Rosie notes that there is flexibility in obtaining parental consent at the school-based clinic because parental consent is obtained at the beginning of the academic year when parents enroll their children in school and provide consent for various school services:

Well, in an outpatient clinic, the parent brings the child and so automatically you would then have the parent sign for consent. Some adolescents can come on their own if the parent brought them and then never became part of the treatment, so then the adolescents would come on their own. So for the schools also it’s a benefit for the parents to sign at the beginning of the school year. Sometimes we have kids that want to come for mental health and they don’t want their parents to find out that they’re in mental health. So, with them, we will send a packet with them so then they could have their parents look at it and come in and talk to us.
Rosie’s experience indicates the way in which the adolescent access mental health services is facilitated in school-based mental health clinics as opposed to community-based mental health clinics. Even though parents provide consent for adolescents in the school-based clinic, adolescents are able to come on their own after parental consent is obtained.

**Intakes**

The theme “intakes,” or “assessments” refers to an initial evaluation. The intakes occur before mental health treatment is provided to clients. The practitioner will obtain consent before beginning the intake, and efforts are made to pursue information from other sources, including the client, family members, significant others, and/or current or past clinical practitioners. In mental health clinics, practitioners conduct intakes to explore the current concerns, goals, and symptoms of clients seeking mental health treatment. The intake process seeks to understand the clients’ risk behaviors, social network and resources, environmental factors, family networks, and medical and psychiatric history (including medications and adherence to treatment). Much of the information is obtained through the use of different forms to document the relevant clinical, family, social history of the client who is seeking mental health treatment (NYS OMH, 2009.)

Practitioners reported that, in order to complete intakes and grant access to mental health treatment, parental consent has to be obtained. Therefore, once the need for mental health treatment is identified and parental consent is received, clinic policy requires the completion of an intake. In clinic settings, practitioners report that the intake includes several forms that must be completed. Once the forms are completed, the adolescent patient is scheduled for treatment. Some practitioners noted delays in delivery of treatment services due to a long required intake process. Lastly, intakes or assessments relevant to diagnostic psychiatric information are
required by insurance companies in order to pay for the mental health services received (Diaz, Peake, Surko, & Bhandarkar, 2004; Mechanic, 2008).

Kailey, who has extensively worked with adolescents in youth development and community-based clinics relays her experiences with conducting intakes in community-based mental health clinics before adolescents begin mental health treatment. She notes having to obtain parental consent as part of the intake process before adolescents can access treatment and engage in services. Consequently, the intake process is lengthy and is also coupled with long waiting lists where parents and adolescents must complete various steps in order to be admitted for mental health services:

I’m going to obtain parental consent before completing an intake for the adolescent to begin treatment because this is what I have to do. In the mental health clinic, we had a minimum of a three-month wait list. At the end of that three-month wait list period when they gave you another call, if you were still seeking services, then you’d be invited for a screening appointment. At the screening appointment...you needed to come on time. If you came five minutes late, you had to wait for another appointment. The screening appointment, first, they would take you in, have the group setting, explain all the forms, all the policies of the clinic, all these different things. Everybody asks questions in there. They sign things there. From there, whoever the clients are, if it’s an adult on their own or a minor and their caregiver (a minor has to have the caregiver), then they’d be assigned to meet with clinicians separately. Then the clinician would review those forms again, speak with them about them. There were so many forms. Then we talked. That was pretty brief. The second appointment would be with another clinician so we’d have another perspective. That would be the intake appointment. The intake appointment, if it’s for a minor, they’d come with the caregiver again. The caregiver, it was a discretion of the clinician how much the caregiver was involved with that and also if you’re going to have the young person or the client in the room alone, the caregiver in the room alone too. Then you get assigned your clinician. The third appointment, then you have your assigned clinician. If you show up late to your intake, then you have to reschedule. I think they did all these barriers so they’d be more likely to get clients who are going to adhere to the attendance and follow through with treatment. All this within a month, you admit them and you have your treatment plan done.
Kailey expressed her frustration with the long intake process and the many forms required for completion by the parent before treatment could begin for the adolescent. She also noted that this process acted more as a barrier to treatment rather than facilitating access to mental health services.

Cindy also noted an extensive intake process at mental health clinics before an adolescent can begin treatment. She was told that these are the policies of the clinic and therefore must be adhered to in order to complete the intake. Furthermore, Cindy also takes time to explain her role and the nature of mental health treatment to ensure that the adolescent fully understands the scope of care:

They complete the intake before gaining access to treatment. They can sign all the appropriate paperwork. You know intake, there’s a medical form, there’s a consent form, there’s an explanation of the privacy practices, there’s an explanation of the rights and grievances, what their rights are as a client of the clinic. There’s a welcome letter that, you know, details the services that we offer and the hours that we’re open and the emergency contact information and the clinician’s contact information. I explain my role as a therapist, then the adolescent and parent agree to meet with me. During the intake, I further explain my role and the services that I would be able to offer and I explained all of the paperwork to be signed and what the purpose of the paperwork is.

This intake process does not seem as cumbersome as the one described by Kailey, but there are still several steps to complete before treatment can commence.

Similarly, Jaime notes that he has had to complete intake forms in order for adolescents to begin mental health treatment. In his experience, the intake was also a lengthy process. He reports that at the community mental health clinic where he rendered mental health treatment, he often had to engage the adolescent in order to complete the intake process before an adolescent could access mental health treatment:

They will be an intake with the caregivers that usually last about three sessions, so they’re collateral sessions. I believe that has changed
recently and I think that has a lot to do with the changes that were made to requirements. But we do three initial sessions with the caregivers just to get a full psycho-social history, medical histories, all different types of stuff. Then we will start meeting with the young people who often times they’re not want to be there, it was really different. It was like day and night going from the first community center to the second one, cause the second one the parents were the ones who would bring them, and so there was a lot more resistance. So my job with that was to build, like I said before, that therapeutic alliance where they saw the benefit, and the engagement process for many of them took months. It was more difficult to engage with the young people at the setting where the caregivers were the ones that wanted the service for the young person. Just to get full psycho-social history, medical histories, all different types of stuff. So that would be part of the intake process.”

If a 16 yo walked into clinic and wanted to get mental health services they were informed that they needed to get their caregiver to come in to talk. I remember having a number of young people that I was working with that said, I have a friend that wants to come to counseling, but they can’t.” “I’m like, okay I encourage you to ask them to come. Here is my information have their caregiver give me a call and we can set up the process for the intake. And they’re like, No they don’t want to tell their parents about the situation.

Jaime notes the arduous efforts required in his role as a practitioner in order to engage adolescents in mental health treatment before and after the intake process. In addition, he reports that some adolescents resisted treatment if parents were the ones providing consent to access and begin mental health care. Therefore, Jaime believes that the obtaining parental consent during intake interferes with the delivery of adolescent mental health services.

Practitioners’ Response to Informed Consent

The exemplar Practitioners’ response to consent, describes the practitioner’s response to consent, which requires them to take an active role with the adolescents and their families in order to facilitate mental health treatment; it answers the research question, “How do practitioners understand and describe the impact informed consent has on adolescent engagement in mental health treatment?” The themes that emerged from this exemplar include “parental
involvement” and “confidentiality.” Participants reported that, due to the nature of obtaining parental consent for adolescent treatment, as dictated by clinic policies, they use parental involvement to facilitate adolescent engagement in mental health treatment. However, due to clinic mandates to obtain parental consent, issues of confidentiality emerged for the practitioner. Furthermore, participants also noted that parental involvement and confidentiality are important in building the therapeutic relationship.

**Parental involvement**

The theme, “parental involvement,” refers to the role parents play in adolescent mental health treatment and how the practitioners respond to parental involvement. According to the literature (see Bannon & McKay, 2005), parental involvement impacts the ability of adolescents to participate in mental health care. For example, a lack of social support, the affordability of transportation, and the negative expectations for treatment affect how a parent can impact adolescent participation in mental health care. Practitioners are often in a position where they must balance adolescent and parental preferences in their adolescent’s care and the parent’s perception of mental treatment. Consequently, in order to improve the efficacy of treatment, practitioners will respond to this situation by finding ways to meet the needs of the adolescent while at the same time addressing parental concerns.

Jenna reports that the challenge, as a practitioner, is to figure out how to keep the adolescent in treatment when parents are involved in their care. Jenna’s experience with parental involvement has led to challenges in supporting the adolescents she has worked with. Even when the parent prefers to be involved, the adolescent may discontinue care for unclear reasons. Jenna sees her role as doing the best she can to develop an alliance with adolescents so that they
can participate in mental health treatment while also trying to maintain positive parental involvement:

It’s interesting now that I’m thinking about how I answer that, I have a harder time getting adolescents into treatment with parents who don’t want to consent when it’s clear that they need it and who are not involved with them. I can work around- if a parent wants someone to be in treatment and the young person doesn’t want to be in treatment, I feel like it’s my job to figure out how to make it something beneficial for them, whatever that looks like, and to have them consent to that, that it’s a partnership and this is something that they could benefit from. Do I know what happens to the people, to the adolescents who don’t consent or are not involved? I don’t because most of those whose parents consent didn’t come back. It’s not like the parents called me and said, “So they’re not going to come. I don’t know what happens at home when and adolescent doesn’t come to treatment anymore. I guess only parent knows that.

In this case, consent is only the beginning of a process that aims to engage adolescents in their own mental health care.

In my interview with Helen, she reports that after parental consent was obtained, some parents chose to be involved with their child’s care while others did not. In her experience, adolescents had an opportunity to decide whether their parents should be involved in the treatment process. In some clinic settings, however, parents were involved as part of the clinic’s practices. Therefore, Helen incorporated a family-centered approach as a way to engage adolescents and inform parents of the nature of treatment:

At the community mental health clinic, I would have a connection to the adolescent but then the adult, has to consent and sign off on it, excluding in any way how the adolescent was a part of the conversation and that that’s what it was really about. It is complicated, because I was just thinking about the school based program where I didn’t have to get parents involved, some parents however did become involved. But it was a decision made by the young person and I reached out to the parent and they (adolescent) knew about what we were doing, and the parent became a bit more involved, not a lot, but at least the adolescent knew it. The clinic was different. It happened automatically, my parent has to consent and be involved. The adolescents knew it was inevitable and I
had to take a family focused approach to be able to inform parents and adolescents what was happening.

The two examples noted above demonstrate the way in which different consent policies can impact the treatment process as a whole.

On the other hand, Henry reports that, in his experience, parents have usually been involved with their adolescents’ mental health treatment, sometimes resulting in positive outcomes. He reports engaging parents (even separately from his treatment of the adolescent) to help them and their children work together. Henry understands that parental involvement is an important facet of the adolescent’s mental health treatment and supports collaboration between parents and adolescents in order to support treatment objectives:

Sometimes, you have parents who don’t want to be involved or who feel like the focus is more on the child that that’s the problem. Where it’s often just not. That’s not the case that it’s just the child’s problem. I have been treating an adolescent who is now 18. When she was 15 she always came with her mother for many reasons. In the beginning I could not have family sessions with them together. I have to meet with them separately because they were not getting along. Now they are engaged and come, they get involved. I think for her, she wants, these are one of the few places where she can have some time with mother and can talk to her. And the mother is still coming so there’s still something, as difficult as this case is there’s still something to it.

In this example, parental involvement has benefits that go far beyond matters strictly pertaining to consent.

Similarly, Rosie reports that parental involvement in her work with adolescents has strengthened the adolescent’s home environment because there is a collaborative approach to the problems the adolescent may be facing. Engaging the parent has supported Rosie’s treatment interventions and has also supported the adolescents participation in care:

When parents are positively involved, I am able to provide the services that an adolescent needs and the support. I can directly help when the
parent is involved, for this girl, it was helpful for me to have the mom involved. We talked about parenting issues and things that have changed the home situation. I find that the service is just more comprehensive when there is somebody involved. And that you’re able then to work in collaboration with the parent, to then help this child. Because in the end, they go home.

Jaime also engages parents and reports that when they are involved, the adolescent can see the positive impact that is yield by parent-child collaboration:

There is something to be said about a caregiver being involved and being the decision maker and getting treatment for the young person. I’ve seen caregiver stay with it (treatment) for a year, two years and the young person finally opens up to the point where they could benefit from treatment was impactful. So that kind of support from the caregiver is very critical. I can see the benefit of the young person continuing treatment, I could provide that kind of psycho-ed about the benefits of continuing ongoing treatment. But unless the young person doesn’t see it for themselves and there is no caregiver support reminding them, then it’s easy for some young people to not be engaged.

Jaime also concludes by reporting that, in his experience, when parents are not involved in their adolescent’s mental health treatment, the risk for treatment drop out is high.

**Confidentiality**

The theme “confidentiality,” refers to the goal of the practitioner to establish a trusting relationship with the adolescent by bridging concerns about privacy. Establishing confidentiality ensures engagement and the continued use of mental health services. Confidentiality plays a pivotal role in ensuring that there is adequate disclosure of mental health information, which protects and optimizes the safety of the adolescent receiving care (Isaacs & Stone, 2001; Taylor & Adelman, 1989). However, maintaining confidentiality with adolescents while at the same time involving parents poses challenges for adolescent-centered treatment. In the study, practitioners discussed the limitations on information sharing. Schachter et al. (2005) suggested using the following phrasing when discussing confidentiality with adolescents: “This is what I
want to talk to your parents about” or “Are there any parts we should keep between the two of us?” Using these types of phrases can help bridge confidentiality issues that may emerge in adolescent mental health treatment and can therefore help to form strong therapeutic alliances.

Informing parents of confidentiality was an important part of Cindy’s role as a practitioner. She reports that drawing parameters around confidentiality and explaining its importance to parents may help adolescents use mental health services:

When I have to get consent from parents, sometimes, parents will ask me well you know what did he or she say and I’ve had to explain the limits of confidentiality. On thing that I do say to parents and you know teenagers, if the teenager wants me to tell you something that came up in therapy, they can tell me to do that and I can do that. I try and explain it so that everybody’s on the same page about what can be discussed about the teenager’s treatment.

Establishing clear guidelines during the beginning stages of treatment can help practitioners avoid conflicts concerning confidentiality.

Renee also believes that confidentiality is important in the utilization of mental health services. He shares the fact that confidentiality helps to build trust in the treatment process and that part of his role is to protect that for the adolescent:

So it’s very important part of treatment that confidentiality be strictly preserved and that the adolescent’s trust in me is built on that. Part of what we’ve talked about as potentially sometime in the future that adolescents might be able to disclose when they are ready. And up to know, I am the recipient of that confidential information. So he or she is not consenting me to sharing certain information with parents, and I’m respecting that. So it completely affects treatment. For this kid, mom loves him and wants to help him and they have other concerns about him etcetera. I always tell him, mom wants to meet with me, and what should I talk to mom about. And we have a full discussion about it, so that he’s completely comfortable about what is said.

As stated by Renee, he protects adolescent confidentiality and will always ask the adolescents for permission to disclose the content of their treatment sessions. Parents are involved in the
treatment but to the extent that the adolescent is aware of what will be shared with the parent. In this way, Renee protects the adolescent’s privacy and helps the adolescent utilize mental health services.

Helen describes her role as also involving parents and, at the same time, confidentiality was essential in her communication and treatment protocols with adolescents and their parents. In her experience, parents were also a part of the treatment and important for the utilization of mental health services by the adolescent:

I think there is a lot of jockey between me and the needs of the parents, because you want to have an alliance with them, because they’re people too, and they have concerns. Especially in outpatient, if they didn’t stay involved, then the kid wouldn’t normally stay involved, because there was this implication that the parents kind of had to be involved. I felt like maybe that’s how I had to work on the trust a lot more, is really just checking in with the young person a lot more about how they’re doing with the process, given some of the things that are happening in terms of just family-dynamic stuff. So confidentiality is different when you are working with families. You have to negotiate. What am I going to say? What am I not going to say?

For Helen, maintaining confidentiality was essential in her work with adolescents. As providers, it was important to inform parents and also inform adolescents of their privacy during treatment. As noted by the study participants, confidentiality was an important part of adolescent utilization of mental health treatment.

Denis reports challenges in maintaining a relationship with adolescents in which, he supports parental involvement under the condition that confidentiality is upheld and respected. Dennis will only report what the adolescent has consented to, which (as was the case in previous examples) helps develop and maintain an alliance with the adolescent:

Yeah, I think that’s a very challenging…parents are a very, very challenging issue when it comes to treating adolescents. And from an agency standpoint, I thing it’s something that we face on a daily basis
with parents wanting to know if “Johnny,” is here…Our policy is about trying to maintain as much confidentiality about the delivery of services as possible. So we only provide the information that we need to provide to those that we are legally required to do so. I think that the parent really wants to know that their child is safe. But we also have an opportunity to help make sure young people who have no relationship with their parents or guardian feel supported in that there are practitioners that care for them and are concerned about their welfare. In so many ways we do become like parents and guardians for those that are not supported by them. We have an important relationship and role with them.

In such cases, maintaining confidentiality can help the practitioner develop a relationship with the adolescents that is otherwise missing from their lives.

**Treatment Consequences of Consent**

The exemplar *Treatment consequences of consent*, describes the issues that emerge in treatment for the practitioner when consent is obtained, and answers the following research question: “How does informed consent affect adolescent access to mental health treatment and utilization of services as perceived by practitioners?” Practitioners encounter a myriad of attitudes and practice patterns in mental health clinics that affect how mental health care is provided to adolescents. The themes that emerged from this exemplar include “*resistance,*” “*trust,*” and “*parent involvement.*” These themes are consistent with the literature regarding the provision of health care for adolescents. According to Campbell (2006), adolescent mental health treatment is complex because clinics’ practices vary based on their interpretations of state laws and regulations. Other variables that make treatment complex include privacy, trust in practitioners, and diverse adolescent capacity and competence to consent for care. Along with the noted variables concerning adolescent mental health treatment, practitioners also need to consider parental responsibilities as dictated by statutory laws.
In addition, practitioners must act in the best interests of their clients (Rhodes, 1986). Therefore, practitioners strive to develop trusting relationships with the adolescents while at the same time protecting their privacy and respecting the autonomy and decisions of both parents and adolescents. Consequently, these competing factors can create barriers to treatment utilization and retention (Campbell, 2006; Halasz, 1996). Practitioners in this dissertation study discussed the ways in which parental consent can cause resistance for adolescents involved in mental health care, and how it can potentially damage the trust between practitioner and the adolescent.

**Resistance**

The theme, “resistance,” refers to the adolescent’s disengagement from mental health treatment. This disengagement is manifested by the adolescent not being an active participant in care (Jivanjee et al., 2009). Additionally, when resistance builds, the adolescent will stop showing up. The theme “resistance” and “stop showing up” were used interchangeably by practitioners in the study, to refer to adolescents not being an active participant in treatment. Practitioners reported that when adolescents are not provided with the opportunity to be directly involved in the decision to participate in care, they will generally not participate during the course of treatment. This resistance to participation builds until the adolescent eventually withdraws from care altogether.

According to Bello (2010) and Jivanjee et al. (2009), under statutory regulations, adolescents are considered incompetent to make decisions regarding their own care. Therefore, parents and legal guardians are then responsible for making decisions on the adolescent’s behalf. However, when parents are the decision makers and adolescents are not part of this process, the adolescents consequently do not actively participate in their own mental health care. Resistance
subsequently emerges and this can create barriers to treatment retention. Practitioners in the study noted that the resistance to treatment can become overwhelming; they then must make the effort to connect with adolescents in order to help them be active participants in the treatment.

Yesenia describes a challenging process of engaging adolescents in order for them to enter and remain in treatment after the decision to obtain parental consent is made. She describes it as the “pink elephant in the room” and notes that resistance emerges due to adolescent concerns regarding parental consent:

Then the resistance for the adolescent after parental consent is obtained will build a little more and it would be harder to work. In that sense, I would say then, with teenagers particularly, the engagement piece is such a big piece. If there is no engagement after parental consent is obtained, we could see a teenager over and over and over but there’s not work done because the elephant in the room hasn’t been able to be removed, name or get out of the room or jump out of it. It’s still there….the elephant in the room, is that you are here to make my parent feel better about themselves because I’m having issues and they feel that now they are doing something to help me. When that appears into the room, it was much harder to work with them. When you obtain parental consent, the adolescent may feel like you’re not here for me. You’re just here to make my parent feel better about themselves because I’m having issues and they feel that now they are doing something to help me. When that appears into the room, it was much harder to work with them. To move forward, it’s like the work has to be pretty much and all the work was there all the time or you cannot move forward and past that. At the other clinic, the Article 28, the teenagers that go there, they felt themselves to be out there because they wanted treatment and were open enough to try it versus the ones that never wanted.

At the clinic licensed as an Article 28 (and where parental consent is not sought), the teenagers who go there are only there because they themselves want treatment and were open enough to actively seek assistance.

Cindy raises many complex issues that emerge after the decision to obtain parental consent is made, including lack of trust and difficulty engaging adolescents as active participants in their treatment. For adolescents who are directly responsible for their own mental health
treatment, the resistance does not come into play because they have been provided with the opportunity to make decisions regarding their care. In her experience, adolescents preferred for their parents not to be involved, and if the parent consented, Cindy often felt like she had to try harder to help adolescents actively participate in their own care:

It can take a little bit longer of time for there to be an, a gook therapeutic alliance. Because of the parent, you have to go to therapy. So there is some resistance to their participation. When the kid comes on their own, it just kind of flowed better, because she made her own decisions of what we talked about, what the issue for her was and what she wanted to improve upon or fix. So it’s different. When I get consent from the parents, I can say the difference between the two with some kids, the parent’s they will just kinda not so involved and not engaging. So then, I have to work a little bit harder to get the kid to trust me. So not that I’m disregarding what the parent is saying, but I have to try and be like okay what do you think is the problem and then we’ll go from there.

As with Yesenia, in these cases, parental involvement was more an impediment to successful treatment outcomes than anything else.

Rachel noted that during the course of treatment for an adolescent female patient, the parent was actively making decisions regarding adolescent care. Consequently, the adolescent did not want the parent’s involvement in her care, nor did the adolescent request for the parent to participate in treatment decisions, resulting in the adolescent dropping out of treatment:

During the course of treatment, Mom wanted her (adolescent) more social and she wanted…”She just needs to talk to a therapist and she’ll be fine.” And the kid was kind of like, No, this is not what I want,” so it was kind of an example of a parent maybe pushing it on the kid and the kid being like, This is not helpful for me. This is not what I want. Eventually, the kid stop showing back up again.

Once again, the treatment outcome was negatively impacted by the involvement of the parent in the process.

Rosie’s experience is consistent with Rachel’s and Yesenia’s. She reports that one of her adolescent patients disengaged from treatment after her parent wanted to become involved in the
When the adolescent and parent goals for treatment are not aligned, adolescents will not participate in their care and inevitably will stop attending sessions (Kazdin et al., 1997; Mckay & Bannon, 2004). This was the case with one adolescent in particular:

Well this kid was 15 and I saw this kid would come to see me. She was very consistent in attending sessions and as soon as we said your parent wants to meet with us, the kid stopped like she would come really late, or come in because there were mini crisis and she then didn’t show up. At this point she eventually stopped coming.

Similar to the other examples, parental involvement marked the point at which the therapeutic relationship began to decline.

Kailey had similar experiences to the other practitioners concerning adolescent resistance to mental health treatment. Kailey reported an example of a parent who made the decision to initiate treatment for an adolescent whose treatment needs were not aligned with the parent’s. Consequently, since the adolescent did not agree to the parent’s decision to initiate care, the adolescent did not return for services:

There were some that I remember went through the screening intake process and if the teens were really opposed to treatment, they were angry at the caregivers, then they wouldn’t ever show up for treatment at all. I remember this boy, the parents were sending him because he was gay and they wanted him to be fixed. The boy said, “there’s nothing wrong with me, explain it to them. He never shows back up even after trying to get him to stay in therapy.

In this instance, the question is whether or not the adolescent should have been brought in for treatment in the first place, raising another area of concern in the matter of parental involvement.

Brenda has also experienced the resistance of adolescents who are not willing to participate in mental health treatment if their parents are involved. In many of these cases, adolescents will not see that they may have mental health needs. Nonetheless, Brenda
understands the parent’s perspective and describes the difference in resistance between parents who are involved in the mental health care of the adolescent versus adolescents who are able to come on their own:

I think if you have a kid who is coming on their own and saying, I’m not involving my parent. I’m really motivated and I want to do this,” I think you’re going to have less resistance in general. I think it’s going to look really different in what wanting to be open is going to be there more for those teenager consenting for their own treatment. We have teenagers who are here because their parents are making them come and they absolutely do not want to be here and they don’t see a problem. When it’s this mandate from the parent, that doesn’t work very well but I understand the position parents are in.

Even though parental concern may be warranted, the involvement of the parents in the decision to initiate care still leads to unsatisfactory outcomes.

All of the participants above reported that adolescents are more engaged in mental health treatment if there is no parental involvement. When parents are involved and provide consent on behalf of the adolescent and consequently dictate treatment outcomes, there will likely be resistance on the part of the adolescent to remain in treatment.

*Trust*

The theme “trust,” refers to the cultivation of a collaboration between practitioner and adolescent that strengthens the quality of the therapeutic relationship and positively impacts the resulting mental health treatment. Establishing and maintaining trusting relationships between practitioner and adolescent is deemed important in mental health care because doing so affects how mental health services are received by the adolescent. Trust in mental health care can be facilitated by the practitioner adopting a patient-centered approach to treatment that will inspire trust, encourage open communication, and value the adolescent as a partner in decision making.

Establishing trust improves the therapeutic alliance and is linked to better adherence and
treatment outcomes (Mey et al., 2013). Practitioners in the study indicated that gaining and maintaining the adolescent’s trust in the treatment process does affect the therapeutic alliance and the resulting mental health treatment outcomes.

Kailey talked about the efforts she makes to establish a trusting relationship with the adolescent. She emphasizes the importance of outreach in helping the adolescent stay in treatment. Additionally, she attributes adolescents’ participation in mental health treatment to their perceptions of the practitioner and agency:

There’s going to be young people who will take their time and they’ll tell you that, “I’m guarded.” “I do not trust.” They’ll take longer to warm up which is a good thing for me to know that the sharing and it takes longer for them to warm up and that’s fine.” Also when they don’t follow through on their counseling and you do outreach, it could be because they didn’t feel a trust and that’s that. I mean, the one’s that keep coming back are the ones that do feel the trust. It’s definitely how I make efforts to connect with the young person. I have to try and get them in and keep the trust. How me and our department is perceived in the agency are two really huge factors in engagement and building trust with the kids. Part of it is because counseling is stigmatized because it’s counseling.

For Kailey, establishing trust therefore involves overcoming some of these preconceived notions concerning the nature of her work itself.

James also notes that the adolescent’s perception of the practitioner is important in determining whether a therapeutic relationship can be established and maintained:

The big trust issue becomes around the difference between the therapist and the patient and how they (adolescent) perceive the clinician as being able to understand them. They needed to figure out what it was that I was going to do as their therapist. I was there to listen to their problems and help them figure out how to make some changes in their life and building this relationship took time.
Similar to Kailey’s experience, an important part of the treatment process is redefining what therapy means to the adolescent and providing him or her with details about what to expect.

As a practitioner, Keith reports that he maintained trust in his work with adolescents by maintaining the confidentiality of their treatment sessions with their parents. For adolescents, trusting the practitioner often relies on how much privacy the practitioner can maintain, therefore, enabling alliances and continuity in treatment:

Considering that for most adolescents that come to treatment the parents must consent right up front during the intake process and during the initial stages, in that case we sometimes may have to bring the parents in with the adolescent and in our conversations to develop sufficient trust in the therapeutic relationship by making sure that nothing is said in front of the parents about the client that the client isn’t privy to. Building trust is also about making sure we keep things private for the adolescent. This way we also maintain a good relationship and the kids keep coming.

Even though the parents are the ones to consent during the intake process, the adolescents must believe that the information they divulge will be kept private if trust is to be established.

Rachel also reports that gaining trust in the therapeutic relationship determines how much will be shared with the practitioner. The practitioner is perceived as a stranger and, therefore, gaining trust between the practitioner and adolescent is vital to maintaining a therapeutic relationship:

Well I think whenever anyone comes to therapy there’s always this but there’s usually this kind of hesitation to share with the therapist, I’m gonna share certain things with a stranger, what is that gonna feel like, what are the potential consequences of that and so I think there’s always kind of once I put it out there, it’s out there. So I think it has a big impact on what the client chooses to say and maybe at what time they choose to say it. When trust is built further down the road it might be a little bit easier but not necessarily.
Even after a certain level of trust is established, adolescent clients might still be reticent about disclosing too much information during treatment.

As might be expected, Helen reports that building trust with the adolescent has been affected by parental involvement. She also describes the challenges of establishing a therapeutic alliance with the adolescents. The challenges for Helen included finding ways to ensure that adolescents were active participants in the therapy while also satisfying her obligation (as dictated by the clinic) to include the parents:

It was more effortful to establish trust with young people at the outpatient clinic. I think partly that now that I’m talking about it, I am needing to make it cooperative. Making sure the youth had a voice. There’s a lot of work that I feel is involved in the outpatient clinic. There was definitely throughout my years of working in outpatient clinics, that some youth did not connect with me. I guess it was hard, getting young folks to come in and come in consistently, either with their parent or not, was a lot harder in outpatient. I don’t think they could ever fully own the process as long as parents were involved. For me personally, sometimes you look back and you say, could I have done something different or were there other things that were happening. Could I have violated their trust? I don’t think I ever did but you never know. When it’s outpatient the parent is there. They’re going to be a part of bringing the young person, so I tried to take more of a family focus.

In that particular setting, this focus was a deliberate attempt to balance the sometimes conflicting desires of the adolescents and their parents.

Working in both school-based and outpatient mental health clinics, Rosie reports that in her experience, adolescents will not trust whenever parents are involved. According to Rosie, part of the trust revolves around what is said in the sessions between the adolescent and the practitioner and how much is subsequently shared with parents:

I mean the treatment it’s different when parents are involved, I mean you would be treating a child, you know, and you would be providing the services, so the actual treatment would be so different until it comes to issues where you have to involve the parent. Then they won’t trust you
anymore. We have kids that come and say I’ll tell you this, but you can’t
tell anyone. As a practitioner I need to establish trust in order to help the
adolescent stay in treatment.

The perception on the part of the adolescents seemed to be that parental involvement was not
wholly compatible with their desire to have their privacy safe-guarded.

**Parental involvement**

The theme “parental involvement,” emerges again in this exemplar and refers to the way
in which parental involvement affects adolescent mental health treatment. When parents play a
role in adolescent mental health, their involvement can sometimes determine whether or not
adolescents utilize the mental health care. A parent’s satisfaction with the mental health care
affects the adolescent’s engagement in treatment. Whether the parent’s involvement is positive
or negative, their influence affects mental health outcomes and participation for the adolescent.
Riley, Stromberg, and Clark (2005) reported that parental involvement is essential to initial
engagement and continuation of care.

Rachel notes that in her experience adolescents become more involved and engaged in
their treatment when their parents are not involved. According to Rachel, a greater sense of
empowerment for the adolescent and an establishment of an alliance with the practitioner occur:

When I worked at a school based clinic in a high school, we did not need
parental consent. The kids felt empowered knowing that their parents
weren’t going to be involved and they weren’t going to, it was almost
like more of a guarantee, “my parent’s aren’t going to know everything.
I think when the parent brings a child in, there’s kind of a meeting event
though you were the child’s therapist and you meet with them once a
week. I feel like there’s still this underlying fear the kids have that what
are you actually telling my parents. I always check with my kids and ask
them what to share. So when there isn’t that parental involvement,
sometimes I think the kids feel more open and relaxed to share things. In
general, I feel like when it comes to adolescents, they’re seeking
independence and they kind of like things to be more on their terms.
Even though Rachel takes steps to assure students that their confidentiality will be maintained, these steps still create an impediment to full disclosure on the part of the adolescent.

Mickey notes that most of the adolescents whom she has treated have been resistant to parental involvement. The resistance of adolescents stems from fear and their concern about parental involvement in the therapeutic process. Mickey provides an example of an adolescent female who admitted that her parent “dragged” her to therapy:

The young person is usually scared when parents are involved. Sometimes even confused. In the instances where the parent has asked the child to wait outside my office while they talk to me, there is confusion and anger from the adolescent. And they come in and they look at you like they’re scared. Because usually when parents come in, it’s like they’re being brought over as a punishment. So when I see that face, I usually tell them there’s nothing wrong with you. The instances where the child has been in my office with their parent, they’re usually, 90% of the time, they’re quiet or they have their head down or they’re upset.” “And the parent, are like whatever. Or the adolescent are staring at me to see my reaction. I have an adolescent female that the mom would drag her in. Mom would make her feel bad and drag her into therapy because, “you don’t listen.” Then mom wanted to know what we were talking about, and she would drill her. I think that if the adolescent walked in without a parent, I would think it would be a whole different ballgame for a lot of them. It does take time for me to get these kids in-most of them.

The mother’s insistence on bringing the adolescent to therapy was only compounded by her insistence on finding out what had occurred during the session, highlighting some of the concerns practitioners have with involving parents in the care of their child.

Fanny shares an experience similar to Mickey’s where adolescents were resistant and did not remain in treatment due to either the parent not bringing the adolescent to sessions or the adolescent not wanting their parent involved in treatment. In one case, treatment was affected negatively because the adolescent refused to have the parent involved in her care:
Yes, there was a couple that were not successful after parents were involved. They came a few times and they needed a lot of work. In that case also what I noticed was that they didn’t have a very good support system at home. So that was more difficult because the caregiver, couldn’t really commit to bringing the youngster and that was not successful.

I had an adolescent female who came with her guardian. In the initial session, I had to obtain consent from the guardian. She came and said I don’t want to be here. I spoke with her guardian who is her grandmother with the youngster being present and said she really doesn’t want to be here if her grandmother had to be a part of the treatment. I then gave the youngster some other options for treatment.

Even for those adolescents who recognize the necessity of mental health care, the involvement of a parent or guardian can become an insurmountable obstacle.

John describes the differences between parents who are helpful participants in their child’s treatment and those parents who may be intrusive and harm the adolescent client-therapist therapeutic relationship. According to John, adolescents will remain in treatment when parents are supportive and understand the therapeutic relationship:

Sometimes, it depends, it’s a case by case basis. There are different levels of involvement in parenting. Some parents were thrilled that their kids were in treatment and they wanted to be involved and they wanted to participate. But the majority of the parents, I worked with really didn’t care. They were only there because their school was harassing them; you know, Get your kid in treatment or there’s going to be problems. Parents could be really, really invasive and want lots and lots of information that is potentially detrimental to treatment. I think some of the easiest to work with were parents who were involved, but at a distance. Parents who said, I want my kid to feel comfortable getting the help that he needs, so I’m going to stay out of the picture unless you ask for my help, and if my kid wants to bring me in that’s great too. I think those were often the most effective treatments because they were the most respectful of the work.
Understanding the therapeutic process and the patient-therapist relationship includes understanding the boundaries that the parents must respect if they want their adolescents to remain engaged in the process.

As a family-systems-oriented practitioner, Renee actually prefers to involve parents in order to enable adolescents to continue treatment and to increase their participation in their own mental health care. However, Renee will negotiate the extent of parental involvement in the adolescent’s care so that it does not act as a barrier to care:

So the parent wants to talk, they call. I again negotiate it when the adolescent to see if it is okay to involve their parent. I say, Your mom will call me. I’m going to be talking with her, They say okay. What can I say, what can I not say? So more often than not, I want to involve the parent in treatment. And the reason for that, again, I’m a systems family therapist, and I do believe strongly that, you know, all of us, we are relational beings. So who are we in relationship with? And very often, adolescents are in relationship with their parents. So there a lot of what they come in with has to do with what’s happening in the home.

For Renee, the parents can act as beneficial participants in the therapeutic process rather than as impediments to its success.

James reports that in his work at the community mental health clinic licensed under NYS OMH Article 31, parents who consent for their children to participate in mental health treatment and who become involved in their care often dictate the therapeutic intervention. Parents make decisions on the adolescent’s behalf without engaging the adolescent—even though the services were initially sought to help and support the adolescent. He compares his experience at the youth development health center where adolescents who seek mental health services are often directly involved and make decisions regarding their care without parental involvement. In his experience, the adolescents at the youth development center are more likely to participate in their own treatment:
If it’s the parent consents and becomes involved, that affects how adolescents use mental health services. It also affects it in that the child might really benefit from psychiatry but the parent says you’re not giving. That’s my kid. Or the parents says the opposite, you need to set this kid up with meds. Either way, that affects the alliance. The parent who doesn’t want the kid on meds and they really need it, the treatment isn’t going to go where it needs to go. Eventually the treatment fizzles or the parent gets frustrated with it or with you for not being good enough therapist working with a child who is in a pretty complicated depression or maybe he might have emerging psychotic symptoms.” If the parent wants the child medicated and the child gets medicated and the child doesn’t want it, then the child is less likely to want to be involved with you in an open way.

With the 28, adolescents often see therapy as more something to help them with a discreet crisis than to work on bigger plans because parent consent is not necessary. They are more likely to say, I broke up with someone, or some other big crisis happens. There’s a lot more investment with therapy.

James underscores the fact that being able to render mental health services to adolescents without parental involvement is often the determining factor in how an adolescent will utilize treatment.

He reports the openness adolescents have in making their own decisions and consequently becoming active participants in their own care.

**Practitioner Experiences**

The exemplar *Practitioner experiences*, describes the clinician’s feelings about the therapeutic alliances with adolescents after parent consent has been obtained; it answers the research question, “How do practitioners experience the impact of informed consent in building a therapeutic relationship with adolescents?” Practitioners are often at odds over how to render services to adolescents when there are conflicting interests with their parents or caregivers.

Although practitioners may prefer to involve the parents in the care, they share concerns that parents or caregivers may be perceived by the adolescent as intrusive and coercive, and this can
lead to limited access and retention (Kaser-Boyd et al., 1985). Practitioners in the study reported that they will always obtain parental consent and will involve parents in the mental health care of adolescents because it often protects them from criticism, complaints, and litigation. However, parental involvement can cause the treatment with the adolescent to become challenging, resulting in practitioners feeling frustrated.

Furthermore, a clinic’s policies and practices dictate how practitioners should provide mental health treatment to adolescents because of the ethical and legal issues surrounding confidentiality and the adolescents’ capacity to consent for their own mental health treatment (Hickey, 2007; Schachter et al., 2005; Tan et al., 2007). However, most practitioners agree that adolescents should take part in decisions related to their own mental health matters in order to increase motivation for change and to enhance the therapeutic relationship (Taylor et al., 1985).

**Frustration**

The theme that emerged in this exemplar (practitioner experiences) was “frustration”. Practitioners described their feelings regarding their experience with obtaining parental consent and the resulting difference in service delivery and use of therapy with adolescents who consent to their own care. Some practitioners described the effect parental consent had on the therapeutic alliance, producing in them a sense of not being able to meet the adolescent’s mental health needs or accomplish established treatment objectives. Consequently, these concerns produced what practitioners described as feelings of frustration.

During the interview, Helen reports that parental consent has impacted her work with adolescents. As a practitioner, Helen has to engage the adolescents and their parents by reframing the therapy sessions and allowing the adolescents to make decisions regarding the treatment focus. For Helen, establishing therapeutic alliances with parents becomes frustrating.
She describes the “dismantling” of barriers in the therapy sessions in order to retain adolescents in treatment. Helen notes that when adolescents can come on their own to sessions, barriers to treatment are reduced and therapeutic alliances can be established more easily:

In a general way for me, voluntary adolescents come on their own and mandatory adolescents had parent’s consent for them before coming to therapy, will make a big difference, whether it’s the youth or even the family coming, because they want help, are seeking help, understand what the help is about, versus a family or even a youth who doesn’t. Like I said, I think because the outpatient – there wasn’t a thought to have the option for the young person to have consent. I didn’t think about how adolescents reacted who didn’t feel like they even had authority about seeking help or not. I noticed that it made a difference on the services for that family. It felt like with adolescents who were mandated, there was a lot of dismantling that had to go on and it was so frustrating for me. It was upsetting for me to come up with some reason for being together that they could work with. To come up with their own purposefulness around why they’re there. With adolescents who were voluntary and did not have parental consent, it was great. They were there because they wanted to and it made a difference in the work.

As with many of the others, Helen believes that parental involvement only increases the amount of work necessary to engage adolescents in the therapeutic process.

Vivian notes that, in her experience, adolescents who seek treatment on their own have better retention rates and, as a practitioner, she reports that the therapeutic work and treatment alliance are less frustrating. At the school-based clinics, there was less parental involvement, and adolescents directly sought treatment without their parents. According to Vivian, these adolescents were easily engaged and participated in their treatment more willingly compared to adolescents whose parents consented to treatment through the clinic’s treatment program. She reported one rewarding experience with an adolescent girl who was a challenge to work with, but who eventually completed treatment due to the established adolescent-therapist alliance:

There is a clear difference between the school based clinics and the clinic treatment programs. At the clinic parents have consented for treatment
or the school based where the kids have actively sought me out and dragged their parents to come in because I have kids who know me or who’s friends see me and their like, I need to see her. That made me feel like I was accomplishing something with these kids. Those kids that sign for their own consent they’re so motivated in counseling. Their treatment objectives are being met. I worked with a 14 year old girl who gave consent, she is going to high school this fall. She came in with such anger issues and knew she was an angry kid, she know she lashed out. If someone just touched her by accident she would get into a fight with them. During the treatment, she go a scholarship, she got into 15 high schools, she’s on the volley ball team, softball team, she’s well on her way to her future. Unfortunately, her parents are not a part of her treatment. That was so upsetting and frustrating for me. I think it was one of the best things she’s ever done was to advocate for her own treatment and then get it. She is a great example of someone who advocated for her own treatment, really worked hard in treatment, is doing well.

In her experience, Vivian notes that there are adolescents who understand and can identify their own need for mental health treatment. The opportunity that this adolescent was given to access services even though her parents were not involved in treatment enabled her to succeed and achieve her therapeutic goals.

Keith reports that adolescents will be more involved in their treatment when they can come on their own without parental consent or involvement, which is less frustrating for him as a practitioner. Additionally, as a practitioner, he establishes a connection and therapeutic alliance with the adolescent aimed at retaining the client in treatment and helping to accomplish treatment goals which improve retention rates:

In the case of a adolescent who comes in of their own free will and wants treatment they take ownership of the therapy much quicker and makes the work with them easier. It will also depend on the relationship they have with their parents as to how they’re going to utilize treatment. So as a therapist, you need to build up rapport and then they will come in and it is less frustrating for me and we can do the work in therapy.

According to Keith, even when adolescents voluntarily seek treatment, their relationships with their parents can still play a role in the outcome.
Cindy reports that, in her experience, when an adolescent is involved in making the decision about his or her own mental health services there is a greater incentive to stay in treatment. Additionally, there is a stronger therapeutic alliance between the adolescent and therapist. On the other hand, if that decision is removed from them by their parents, then they will not be as engaged, resulting in negative feelings for the practitioners:

Well, I think and adolescent who’s not under parental consent and involvement obviously can say when they need or feel like they don’t need it (therapy) anymore… and that they’ve… they’re solved you know the issue, they feel better you know on a consistent basis, they can kinda make that decision and it makes me feel better as a therapist too. There is less frustration and more therapeutic alliance. Since they have the power to decide that they wanna stop as opposed the parent saying, oh no you still have to go or the school saying oh no you still have to go, you know you’re not okay yet.

In her experience, allowing adolescents to participate in the decision to terminate treatment can actually contribute to better outcomes.

Helen also reports that retention for an adolescent who is not willingly involved in the decision to attend therapy becomes a challenge for the practitioner. In these cases, it is difficult to engage the adolescents and help them continue with treatment. For Helen, it was much easier and less challenging to involve adolescents in the school-based clinics as opposed to the community clinic treatment programs because adolescents in the school-based clinics can participate in their own care free from parental consent and involvement:

When it’s just the adolescent on their own and in their own work deciding I just want to be an independent person in this (therapy), you don’t have to worry about that in the same way. In my experience doing outpatient work with young people, its difficult- it’s hard to keep them coming and I felt frustrated with trying to keep them involved since there parent had to consent and make decisions for them. In school based programs, you’ve got an active audience they are feeling more independent and free with what they want for themselves.
Consistent with the others, Helen found this process much easier at a school-based setting as opposed to a community-based clinic.

Not surprisingly, Vivian (who also works at a school-based mental health clinic) reports that the adolescents she has worked with are motivated for mental health treatment. These adolescent have the capacity and competence to act on their own behalves and have an opportunity to make decisions regarding their mental health care. She reports that the therapeutic work was rewarding and less frustrating when adolescents could act in their own self-interest and be active participants. According to Vivian, they will remain in treatment, and their parents may eventually become involved in their care:

I feel like those kids who are involved with their treatment, are the kids who come to me when they realize something’s wrong, and they know something’s going to happen. But they have enough insight to get help to prevent them from developing bad coping skills. They are insightful and they know what they need. For me as a therapist- it was great and rewarding. I didn’t feel so upset and frustrated trying to get them to stay in therapy. I think it’s unfortunate that sometimes parents do not understand that about their child. There are adolescents who are motivated for their own treatment and they consent. These are the one’s who in my experience bring their parents to me. I would say that most of those parents eventually come around...maybe because as time went on and the adolescent participated in treatment, they (parent) also see the change in their kid.

In Vivian’s experience, adolescents motivated to seek out treatment for themselves, are more likely to involve their parents rather than the other way around.

**Summary of Findings**

Analysis of the data revealed how informed consent impacts adolescent mental health treatment. Practitioners in various mental health settings noted how parental consent impacts their treatment practices and how it is experienced in the delivery of services to adolescents.
Interpretive phenomenology allowed for an interpretation of practitioners’ experience with adolescent informed consent. Through the use of this research method, their experiences were captured through semi-structured interviews to gain a deeper understanding of informed consent as a phenomenon. As the interpretations of their experiences emerged, these were summarized as exemplars. The exemplars in the study captured the experiences of the practitioners and shed deeper light on their concerns, practices, and experiences with consent. The themes stemmed from the exemplars, and practitioners revealed their knowledge of informed consent, which stemmed from their experience with state regulations and clinic policies.

The examination of the way in which practitioners understood the state regulations concerning consent revealed that practitioners will always refer to the New York State Office of Mental Health for practice guidance. Furthermore practitioners will always follow NYS OMH guidelines and regulations for the provision of mental health services. Some participants reported that there may be different interpretations of NYS OMH guidelines by clinic leadership. Consequently, practitioners follow the interpretation of the particular clinic in order to render mental health treatment to adolescents. Practitioners will not veer from these policies and regulations; instead, they will strictly adhere to them in most, if not all, cases. This adherence affects how clinicians provide treatment to adolescents. For some practitioners, obtaining parental consent can be helpful to their treatment; however, some noted that their efforts to engage adolescents in mental health treatment were often arduous because service delivery was often dictated by policies and regulations. There was often a balancing act between policies and regulations and the practitioners’ interest in how best to render mental health services to adolescents.
Beyond the challenges of understanding and working through their obligations to follow regulations and clinic policies, practitioners notably agree that, after parental consent has been obtained, they take an active role with the adolescent in order to facilitate mental health treatment. Building a therapeutic relationship with adolescents was predicated upon how actively the parents were involved with their children’s care. Once parents consented to their adolescent’s mental health treatment, they became involved with the decisions concerning their child’s mental health care. Consequently, practitioners also encountered a myriad of attitudes and practice patterns in mental health clinics that affected how mental health care was provided to adolescents. For example, issues of confidentiality emerged as practitioners found themselves balancing parental involvement and the protection of the adolescent’s confidentiality in order to retain the adolescent in treatment while at the same time adhering to their ethical and legal responsibilities concerning confidentiality and adolescent capacity to consent for their own mental health treatment.

Concerns about adolescent resistance to treatment and the lack of trust between the adolescent and the practitioner were also evident in the study. These themes were interconnected as practitioners described increased adolescent resistance when parents became involved in care and made treatment decisions. In many cases, adolescents eventually stopped participating in their care and eventually disengaged from services altogether. What emerged during the sessions was a lack of trust on the part of the adolescent towards the practitioner, who was therefore challenged with re-establishing therapeutic alliances.

Trust in mental health care can be facilitated by the practitioner adopting a patient-centered approach to treatment that will inspire trust, encourage open communication, and value the adolescent as a partner in decision making. Establishing trust improves the therapeutic
alliance and is therefore linked to better adherence and treatment outcomes (see Mey et al., 2013). Practitioners in the study indicated that they have to gain and continually maintain the adolescent’s trust in the treatment process, affecting the therapeutic alliance and mental health treatment outcomes. Many of these trust issues stemmed from the concerns about the parent’s involvement in the treatment decisions for the adolescent. Similarly, there was a consensus among practitioners that, once parents consent, their involvement in mental health treatment significantly impacts the adolescent’s participation in their own care. For the most part, parents were actively dictating adolescent treatment options and outcomes to practitioners, which led to distrust and in the adolescents disengaging from treatment and resisting ongoing care. This involvement resulted in feelings of frustration for practitioners, who were thus challenged with balancing the adolescent’s trust with the parents’ involvement in the mental health treatment.

Likewise, practitioners agree that feelings of frustration are elicited when clinic policies dictate their practices. Although regulations and clinic polices subject adolescents to parental involvement in mental health treatment, parents may need to be encouraged to have confidence in the mental health practitioner’s competence, in the practitioner’s ability to provide optimal mental health care, and in the ability of their children to be involved in their own treatment decisions (see Kelsey, Abelson-Mitchell, & Skirton, 2007). This observation was noted in many of the responses of practitioners who were willing to involve the parents while at the same time allowing adolescents to participate in their own care. Additionally, practitioners noted their concerns with the way in which adolescents perceive their parents’ involvement in the mental health treatment and that adolescents may assume that parents are being intrusive and coercive, further compounding practitioners’ feelings of frustration. Practitioners agreed that adolescents
should be enabled to take part in their own care because this participation is essential for improved mental health treatment outcomes.
Chapter V: DISCUSSION OF FINDINGS, IMPLICATIONS AND CONCLUSION

Introduction

This study endeavored to discover how mental health practitioners understood and experienced the informed consent process in their work with adolescents. I aimed to describe how informed consent policies and practices influence the therapeutic work between practitioner and adolescents and to examine the impact that informed consent practices had on their treatment of adolescents. Additionally, this study showed how informed consent impacts service delivery and the therapeutic relationship between adolescents and practitioners. Furthermore, the study revealed that clinic policies determine how adolescents access mental health treatment; consequently, these policies also shape how parents are involved in the treatment of adolescents. In this chapter, I will discuss the findings of this study and review how it supported or differed from the empirical literature. Furthermore, I will examine the implications of the findings for clinical practice, service delivery, and future research. Finally, the limitations of the study will also be discussed.

Discussion of Findings

Upon review of the study’s findings, it became evident that practitioners struggle with their knowledge of adolescent informed consent and how to implement it in mental health settings and practice. The practitioners involved in the study noted the way in which clinic policies and practices shaped their experiences concerning adolescent informed consent. In addition, they also recounted their own experiences with adolescent mental health service delivery and with building and sustaining the therapeutic relationship between practitioner and adolescent. Discussion of the study findings will concentrate on the following: (1) practitioner
knowledge of informed consent, (2) practitioner’s response to informed consent, (3) treatment consequences of informed consent, and (4) practitioner’s actual experiences with informed consent.

**Practitioner Knowledge of informed Consent**

The results show that most practitioners follow New York State Office of Mental Health (NYS OMH) guidelines when rendering services at licensed clinics. For example, practitioners noted that clinics adhere to OMH regulations, which are then interpreted by the clinic leadership and disseminated to practitioners as clinic policies. Some of the practitioners in the study reported that there may be different interpretations of the NYS OMH guidelines by clinical leadership, resulting in differences in the way that mental health treatment is provided to adolescents. What emerged out of this finding was the importance of following the policies of the organization regarding adolescent informed consent. This finding is consistent with studies conducted by Schachter et al. (2005), Hickey (2007), and Tan et al. (2007) that also found that practitioners adhere to clinic policies when providing mental health treatment.

The practitioners in the study noted that they obtained parental consent in all cases involving adolescents, unaware that New York State law allows adolescents to consent for their own mental health treatment under certain circumstances. Based on agency policies, practitioners assumed that parental consent is always required in order for an adolescent to begin mental health treatment. This assumption is significant because these practitioners also reported that obtaining parental consent appeared to negatively influence adolescent access to care.

The mental health treatment of adolescents begins with an intake interview which is the initial evaluation before any interventions are provided. According to the practitioners in the
study, clinic policy dictates that parental consent be obtained before the intake process begins. However, practitioners reported that intakes are lengthy and are coupled with long waiting lists, and parents and adolescents must complete various forms in order to begin treatment. Failure to complete these steps result in no provision of services and it creates barriers to service utilization. These findings are consistent with Samargia et al. (2006), which found that adolescents have difficulty gaining access to mental health care because of specific clinic practices such as elongated initial evaluations. Additionally, Power (2003) noted that a barrier to care for children and adolescents lies in the disconnect between clinic practices and the way in which adolescents and their families actually seek mental health care. The findings of this dissertation study suggest that license clinics prefer to obtain parental consent, often resulting in adolescents not actively participating in their own care and not remaining in treatment.

Practitioners’ Response to Informed Consent

Practitioners reported engaging adolescents in different ways and creating alliances with the adolescents in order to help them enter and remain in treatment after parental consent is obtained. Samargia et al. (2006) conducted a study that examined adolescents’ perceived barriers to accessing mental health care. Adolescents in the study responded that no one was available to accompany them to treatment because either the parent or guardian would not go or the adolescents did not want parents to know that they were seeking psychiatric care. Samariga and colleagues suggested that practitioners loop adolescents into treatment by asking questions such as “What kept you from seeing a counselor when you thought you should?” (p. 20). Similarly, the findings of this dissertation study appear to suggest that practitioners must find creative ways to engage and retain adolescents in mental health treatment in order to facilitate a
positive view of mental health treatment as part of a broader plan for lifelong care, well-being, and maintenance.

The study participants also noted that parental understanding of and participation in the psychiatric care of adolescents appear to foster a collaborative approach between the adolescent and parent in managing mental health concerns. Additionally, joint input from parents and adolescents regarding their mental health treatment options seemed to improve treatment outcomes and reduce treatment disparities in the utilization of psychiatric services. These findings are consistent with a study conducted by Cunningham, Deal, Rimas, Chen, Buchanan & Sdao-Jarvie (2009), which found that when parents are involved and are provided with accurate information regarding mental health treatment of the adolescent, they will feel more confident and less stressed, and this results in improved treatment decisions and outcomes. Practitioners also preferred a more collaborative, family-centered approach to treatment in which there is the opportunity to review questions, options, and outcomes. Cunningham et al. (2009) also noted that allowing parents to be involved and to participate more actively in the mental health treatment planning process reduces drop-out rates and yields significant mental health outcomes.

For adolescents receiving care, parental involvement in their mental health treatment can also raise concerns regarding confidentiality. In fact, study participants further reported that adolescents are more willing to use mental health services when they are given the assurance of confidentiality. Practitioners observed that preserving confidentiality during treatment fosters trust and communication within the therapeutic relationship. These findings are consistent with Isaacs and Stone’s (2001) study which found that adolescents are reluctant to enter and use mental health services because of the possible lack of confidentiality. Furthermore, the study also indicated that adolescents are as entitled to confidentiality rights as adults and that their
parents should be made aware of their right to privacy (with the exception of disclosure due to at risk behaviors including crime, child abuse, substance use, or danger to self and/or others).

Cindy, one of the practitioners in the dissertation study, observed that upon obtaining parental consent, parents will usually inquire about the adolescent’s mental health treatment. At this point, she then has to explain to them the nature of confidentiality and its limits. Renee, another participant in the study, observed that the therapeutic relationship is built on preserving confidentiality between the clinician and adolescent. This participant noted the responsibility to protect the adolescent’s confidentiality, and this confidentiality consequently fosters a therapeutic alliance between practitioner and adolescent. Gustafson and McNamara (1987) underscored the fact that adolescents’ decisions to remain in mental health treatment are contingent upon the maintenance of their confidentiality. Thus privileged information that is shared in treatment sessions is greatly impacted by the ability to share privileged information to parents or guardians without the knowledge of the adolescent. Other participants in the study suggested that confidentiality affects the therapeutic relationship and the adolescent’s participation in mental health treatment.

**Treatment Consequences of Informed Consent**

The study found that adolescents are less likely to use mental health services when parental consent is obtained. Practitioners reported that many of their adolescent clients opted to participate in mental health treatment only if their parents did not consent or were involved in their care. Therefore, in order for adolescents to be active participants in their own treatment, practitioners must make efforts to help them maximize their treatment regardless of parental consent and involvement. This was achieved by allowing adolescents to make (or at least be
involved in) their own treatment decisions. Draucker (2005) noted that many adolescents are leery of mental health services and will hold back as active participants in treatment when their parents participate and are the ones making decisions regarding their care. In addition, some adolescent may even try to get out of treatment or shorten the treatment sessions by convincing their parents that a few sessions were sufficient to resolve their problems. Some parents may concur with the adolescents and not follow up with clinical care nor pursue further mental health treatment for their children. Similar to Draucker’s (2005) observations, this dissertation study found that adolescents do hold back in treatment. For example, one practitioner noted the following:

If it’s the parent who consents and becomes involved, that affects how adolescents use mental health services. It also affects it in that the child might really benefit from psychiatry but the parent says, “You’re not giving my kid that medication. That’s my kid.” Or the parents say the opposite: “You need to set this kid up with meds.” Either way, that affects the alliance.

The parent who doesn’t want the kid on meds when he or she really needs it—the treatment isn’t going to go where it needs to go. Eventually, the treatment fizzles or the parent gets frustrated with it or with you for not being a good enough therapist working with a child who is in a pretty complicated depression or maybe he might have emerging psychotic symptoms. If the parent wants the child medicated and the child gets medicated and the child doesn’t want it, then the child is less likely to want to be involved with you in an open way.

According to McKay and Bannon (2004), when parents did not expect mental health treatment to be effective and had negative beliefs about mental health services, their adolescent children reported more challenges with engagement and retention and consequently dropped out of treatment.

McKay and Bannon’s findings were echoed in this dissertation study by several practitioners who experienced adolescent resistance to treatment due to their parents’ negative perceptions of mental health services and the way in which these perceptions affected the
adolescent’s participation and retention in mental health care. Practitioners noted that when parents render consent and are involved in the treatment but are not aligned with the needs of their adolescents, the adolescents will inevitably discontinue treatment. Previous studies on adolescent drop-out and treatment rates (see Kazdin et al., 1997; McKay & Bannon, 2004) are consistent with the findings of this study. Furthermore, practitioners observed that resistance to mental health treatment increases on the part of the adolescent when parents are directly involved in clinical care. Participants in the study reported making attempts to establish a working alliance with parents in order to minimize resistance to treatment. Practitioners developed strategies aimed at establishing a working alliance with the parent and adolescent in the hopes of cultivating a therapeutic relationship that would yield positive results for the adolescent.

The therapeutic alliance is a critical component of the sustainability of mental health treatment for the adolescent. Block and Greeno (2011) argued that the therapeutic alliance consists of establishing a bond with the adolescent that is based on mutually agreed-upon goals and tasks for therapy. This dissertation study found that establishing a therapeutic alliance was an important task within the provider-adolescent relationship. For example, one participant reported that establishing trust between the adolescent and practitioner was necessary to make the treatment cooperative, and the rapport between the practitioner and adolescent was contingent upon how involved the parent became during the course of therapy. According to the participants in this dissertation study, parental involvement—whether at the point of intake or during the course of treatment—impacts the adolescent’s duration in therapy and the treatment outcomes.
**Practitioners’ Experiences**

This dissertation study found that practitioners experienced significant levels of frustration when providing mental health treatment to adolescents. Obtaining parental consent often created conflict in the therapeutic alliance, and the practitioners observed that, in their experience, adolescents have the capacity to make decisions regarding their own care. This observation is consistent with studies that found adolescents to be fully capable of making informed treatment decisions (see Copeland, 2006; Tan et al., 2007; Weithorn & Campbell, 1982). Determining whether an adolescent has the sufficient capacity to make decisions regarding his or her own mental health care may be challenging and may consequently frustrate practitioners. Therefore, within adolescent mental health care, protective policies are usually based on the opposite presumption: that adolescents differ from adults in their capacity for reasoning and in their decision-making ability (Schachter et al., 2005). As noted previously, most practitioners always follow these clinic polices regarding informed consent for treatment. Because of this adherence, practitioners are challenged with how best to engage adolescents, and this often leads to feelings of frustration. As demonstrated by this dissertation study—and consistent with the literature (see Taylor et al., 1985)—practitioners need to feel that they can demonstrate their own capacity, knowledge, and skills in assessing what the adolescents bring to the therapeutic environment. Successful engagement results in increased motivation for change within the adolescent and enhances the therapeutic relationship between practitioner and adolescent.
Summary of Findings

In summary, the findings of this dissertation study appear to suggest that practitioners will always adhere to clinic policies regarding mental health service delivery to adolescents, and that these clinic policies are set forth by clinic leadership and, in New York City at least, are informed by the New York State Office of Mental Health regulations. Directed by clinic policies, practitioners always obtain parental consent at the onset of mental health care. This study found that clinic policies set the structure and criteria for how adolescents enter mental health treatment. One of these structures includes the intake or assessment process. Practitioners reported that prior to mental health treatment, there are long waiting periods for an initial evaluation and, consequently, adolescents often fail to participate in or follow through with mental health care. Prior to an initial evaluation or intake, clinic policies dictate that parental consent ought to be obtained. Practitioners reported that these clinic structures result in a delay in treatment and compromise the development of therapeutic alliances with this client population.

The results of this study also suggest that practitioners need to take an active role in facilitating mental health care and building therapeutic alliances. For some practitioners, once parental consent is obtained, they are faced with balancing the treatment preferences of adolescents and their caregivers while at the same time maintaining the confidentiality of the adolescent. Practitioners noted that these competing concerns often elicit resistance in adolescents particularly if they perceive their parents to be intrusive or coercive in their care. In these cases, practitioners described feelings of frustration as they attempted to engage adolescents in mental health treatment while at the same time involving families and adhering to clinic policies.
Implications for Clinical Practice, Service Delivery, and Future Research

Clinical Practice

Clinical practice requires that practitioners provide mental health treatment information to adolescents and their families as part of the informed consent process. Practitioners in the study were inclined to perceive parental consent for adolescent treatment as essential to therapy because adolescents are under the authority of their primary caregivers. Practitioners also wanted to guarantee adequate disclosure of the risks and benefits of treatment.

However, after practitioners obtained this parental consent, they were frequently challenged by the difficulty of ensuring that adolescents receive the required mental health services while at the same time respecting parental or legal guardian rights and family interests. As demonstrated in this dissertation study, adolescents may drop out of treatment—and this results in poor service delivery and health outcomes. To this end, the therapeutic relationship between practitioner and adolescent is very important in helping adolescents stay in treatment. By establishing therapeutic bonds and agreed-upon goals, practitioners can help adolescents commit to therapy and remain in mental health treatment (Block & Greeno, 2001). According to the literature (see Garland et al., 2000; Munson et al., 2009), adolescents are capable of describing their expectations regarding mental health treatment. If given the opportunity to express their own concerns, this population will generally experience motivation and have a positive perception of mental health services. In order to achieve this, practitioners need to understand that establishing a therapeutic alliance is an important task of the provider-adolescent relationship. In order to establish trust and mutually defined goals, practitioners need to have a good sense of what brings an adolescent to treatment in the first place. Additionally,
practitioners need to demonstrate their capacity, knowledge, and skills in assessing what the adolescent may bring to the therapeutic environment (Copeland, 2006).

Furthermore, practitioners need to establish a balance between addressing the adolescents’ mental health needs and involving parents after consent has been obtained. The challenge with obtaining parental consent lies in how involved the parent becomes during the treatment. Parental involvement—whether at the beginning or the end of therapy—will inevitably impact the course of treatment and its outcomes (Kazdin et al., 1997; McKay & Bannon, 2004). After consent has been obtained, further parental involvement brings with it concerns regarding confidentiality. For practitioners, maintaining confidentiality is important because it cultivates a trusting relationship between adolescents and practitioners. This trusting relationship is one of truthfulness, personal respect, and consideration (Isaacs & Stone, 2001).

Practitioners are faced with the goal of establishing a trusting therapeutic climate that will ensure engagement and the continued utilization of mental health services by adolescent clients. To this end, practitioners must ensure that adolescents receive an adequate disclosure of mental health information that protects and optimizes their health and safety and informs them of risks and benefits to mental health care (Isaacs & Stone, 2001; Tan et al., 2007; Taylor & Adelman, 1989). Adolescents should be able to include their families in mental health treatment secure in the knowledge that their privacy will be protected and may only be breached in certain necessary situations (Campbell, 2006).

Practitioners need to continue to involve adolescents in the informed consent process to the greatest extent possible while at the same time assessing, on an individual basis, their capacity to consent for treatment. In order to achieve these goals, practitioners will also need to recognize that capacity is an evolving aspect of cognitive and psychological development.
Providing access to information about mental health and ensuring an active participatory role may help facilitate adolescent engagement and influences the use and outcome of outpatient mental health services (Adelman et al., 1984; Beeman & Scott, 1991; Taylor et al., 1985; Vukadinovich, 2004; Weithorn, 1985). However, in order for practitioners to involve adolescents with decision-making capacity, practitioners will need to have knowledge about informed consent policies.

**Service Delivery**

Adolescent informed consent carries with it several ethical concerns that do not necessarily come into play when providing mental health treatment to adults, and it is a sensitive issue that easily creates legal and ethical concerns for practitioners, parents or legal guardians, and the adolescents themselves (Koocher, 2008; Roberson, 2007). For example, should adolescents be given full power to nullify their parent’s or caregiver’s consent when it comes to mental health treatment? Practitioners need to carefully assess the competing interests of adolescents, families, and institutions in order for adolescent clients to achieve the full benefits of treatment and support (Koocher, 2008). Practitioners should also understand the mental health laws specific to informed consent for mental health care and the ethical considerations regarding adolescent self-determination.

Some of the challenges facing practitioners are related to a limited understanding, on their part, of informed consent policies for adolescents. There is usually very little consensus among professionals that these policies are necessary. When consensus is present, there is little consistency in their adoption and implementation (Behar, Friedman, Pinto, Katz-Leavy, Jones,
Regulations regarding informed consent are disseminated to licensed outpatient mental health clinics. The clinics in turn pass these regulations to their practitioners. The complexity lies in the interpretation and implementation of these regulations by the clinics or programs and how they are then adopted by practitioners. For example, in New York State, adolescents seeking mental health services can access treatment, including medication, without parental consent under certain conditions, including when the parent or guardian is not available or when the practitioner determines that involving parents may be detrimental to treatment (Feierman et al., 2002; Roberson, 2007). However, this dissertation study found that the majority of the practitioners in the sample were not familiar with this law.

Practitioners who provide mental health treatment to adolescents—but who are not aware of the laws and regulations surrounding adolescent informed consent—face certain ethical challenges. Adolescents have decision-making capacity; however, the lack of information regarding informed consent policies by practitioners results in adolescents receiving inadequate information about treatment alternatives and the risks and benefits of mental health care (see Taylor et al., 1985). This shortfall represents a problem, given that adolescents require more extensive information about informed consent policies than adults, and they present with limited experience in exercising patient rights and self-determination. Kuther (2003) observed that consent issues with adolescents are challenging because their best interests are often subjective, thus leading to debates about whether or not adolescents are mature enough to make decisions regarding their own mental well-being. In order to develop adequate service delivery policies, adolescents’ rights to autonomy and self-determination ought to be taken into consideration by institutions of care. It is also necessary for practitioners to know the laws and regulations regarding informed consent for adolescents, and to ensure that adolescents are adequately
informed about mental health treatment services. It is important to note that when adolescents have a voice in their care and seek confidential access to mental health care, their treatment outcomes are more beneficial than when parental consent is required (Bello, 2010).

Adolescents are a vulnerable population that is susceptible to social morbidities such as poverty, familial stressors, unplanned pregnancies, drug and alcohol addictions, sexually transmitted diseases, limited access to community resources, and fragmented academic resources (see Diaz et al., 2004). More than 25% of all adolescents live in poverty, a fact which contributes to significant medical and mental health challenges among this population (Millstein, Irwin, & Brindis, 1991). Additionally, on a national level, more than 14% of all adolescents do not have health insurance (Newacheck, Brindis, Uhler Cart, Marchi, & Irwin, 1999), often resulting in unmet medical and mental health care needs. Many adolescents with co-occurring mental health disorders go undetected, and sadly some wind up in the juvenile justice system or the child welfare system rather than receiving the mental health services they require (Jacobstein et al., 2007). In order to implement effective programs to fit the needs of adolescents, it is crucial to assess needs, identify gaps, and determine practitioner and community capacities. Most adolescents do not receive adequate mental health care (Powers, 2003; Stroul & Blau, 2008). Regrettably, problems with eligibility and access to care, coupled with fragmented service delivery and inflexible financing systems, create significant barriers that negatively affect effective adolescent treatment (U. S. Department of Health and Human Services Office on Disability, 2005). Additionally, social barriers to mental health services may include cultural factors, difficult parent-child relationships, and shifting practitioner-client dynamics (Power, 2003).
Programs that are youth driven and development focused need to provide services that are generally accessible and devoid of barriers that may discourage adolescents. For example, adolescent mental health services should try and to eliminate the following barriers for youth: poor financial status, lack of health insurance, and the perception that using family health insurance will compromise the adolescents’ confidentiality (Mechanic, 2008; Power, 2003). Mental health services are easier to access when they are grant funded, are comprehensive and holistic (integrating mental and medical health), and have viable financial streams—all of which will support adolescents who refuse to use their parents’ medical insurance (Diaz et al., 2004). As practitioners have reported in this dissertation study, services for adolescents are also effective and safe when they are also confidential. Hence, when practitioners are able to involve parents in a manner that respects adolescents’ decisions and self-determination, they may be more apt to remain in mental health treatment (Samargia et al., 2006).

In order for services to be adolescent-centered and development-focused, Diaz et al. (2004) suggested that adolescents be involved in determining their service needs and in planning their own programs. Their involvement can be facilitated through consumer advisory boards and focus groups concerning key initiatives. This approach can provide adolescents an opportunity to address their concerns specific to mental health treatment and clinical services.

**Future Research**

Replication of this dissertation study is warranted in order to examine how out-patient and school-based mental health clinics implement informed consent with adolescents. The ability to generalize from the findings of this dissertation study to the larger population is limited
because the small sample size of participants; therefore, research with a larger sample size of practitioners is needed to validate further the findings of this study.

Studies that compare the ways in which young people access reproductive health clinics and youth development programs with how they access mental health clinics can deepen our understanding of informed consent with this population. For example, adolescents who access reproductive health clinics can do so without parental consent, but adolescents seeking mental health treatment must meet certain requirements in order to consent for their own care. Additionally, comparative studies of school-based clinics and community mental health clinics can serve to describe the ways in which adolescents seek services in distinct treatment settings and how they perceive care in diverse clinical settings.

Examining differences in socioeconomic, racial and ethnic status of adolescents in affluent and at risk communities can demonstrate how socio-cultural factors impact informed consent practices. As noted in the literature review, adolescents facing poverty and those of racial and ethnic minority status are less likely to receive mental health care than middle- and upper-class Whites (Inkelas et al., 2007; Power, 2003; Stern et al., 1999). If such adolescents are less likely to receive care in the first place, how does informed consent further impact or contribute to these challenges?

Adolescent perceptions on informed consent should be studied in order to determine whether practitioners are soliciting competent and voluntary consent from them and to clarify the effects of consent procedures on treatment processes and outcomes. As noted in this dissertation study, most practitioners were confident that adolescents have the capacity to understand the nature of mental health services, and are competent to participate in treatment decisions. However, because of clinic policies, these same practitioners also felt compelled to obtain
parental consent. Phenomenological studies aimed at understanding adolescent perceptions with informed consent can shed light into how they experience access and utilization of mental health treatment after their consent has been obtained. Furthermore, such a study can demonstrate how adolescents perceive the therapeutic relationship and whether they become engaged and remain in mental health treatment.

Future research might also focus on the study of multiple interrelated variables, such as therapists’ preference for either adolescent or parental consent and their view about adolescents’ decision-making competency. Such research could guide the development of mental health informed consent practices that optimally benefit both the adolescents and their parents. Very often, policies and prevailing practices do not encourage adolescents to participate in decision making regarding their mental health care. Furthermore, additional studies can analyze the influence of parental involvement on adolescents’ decisions to be active participants in their own mental health care. Such studies may assist in creating better parent-child-therapist alliances and engaging adolescents and their families in mental health services.

The following is an excerpt from a practitioner who notes the challenges of adolescent participation in mental health treatment.

At the community mental health clinic, I would have a connection to the adolescent, but then the adult has to consent and sign off on it (excluding in any way how the adolescent was a part of the conversation), and that’s what it was really about. It is complicated, because I was just thinking about the school-based program where I didn’t have to get parents involved; some parents however did become involved. But it was a decision made by the young person, and I reached out to the parent and they [the adolescents] knew about what we were doing, and the parent became a bit more involved, not a lot, but at least the adolescents knew it. The clinic was different. It happened automatically; my parent had to consent and be involved. The adolescents knew it was inevitable, and I had to take a family-focused approach to be able to inform parents and adolescents what was happening.
For this practitioner, such involvement only increased the work necessary to maintain adolescent involvement in treatment.

In order to address informed consent practices, while at the same time increase the involvement of adolescents and their families in needed mental health services, it may be important to do the following: (1) become more familiar with mental health regulations and policies affecting practice, (2) examine the points of entry into adolescent mental health services, (3) consider service delivery options for adolescents based on their input, (4) consider parental concerns and develop strategic ways of involving families in adolescent mental health services (Diaz et al, 2004). The most important theme throughout this study was the ways in which the informed consent process can be better facilitated in order to allow adolescents to fully participate in their own treatment.

Limitations of the Study

The limitations of this study include the use of a small sample size and the length and time of the practitioner interviews. There was difficulty recruiting respondents; therefore, a non-probability, purposeful sampling of 20 participants with similar backgrounds as licensed social workers was used. This sample size nevertheless, was consistent with the purpose and goals of the study as well as the resources available: “The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with sample size” (Patton, 2002, p. 185). Given the small sample size and the sampling strategy used, the findings may not be generalizable to other mental health practitioners.
Despite these noted limitations, the practitioners offered a rich, valid, and meaningful source of data concerning the phenomenon of informed consent. The practitioners express concerns about the length of the interview and the time it took to complete it. The average semi-structured interview took about an hour and a half and was made up of nine questions with each question containing several probes. Most of the participants had scheduling conflicts and needed to make alternative arrangements for their participation in the study.

Conclusion

This study sought to understand the impact of informed consent on the delivery of mental health services to adolescents. Moreover, the study also examined how practitioners experienced informed consent in the treatment of adolescents. The following research questions were explored and answered: (1) How do practitioners understand adolescent informed consent? (2) How does informed consent affect adolescent access to mental health and utilization of services? (3) How does informed consent impact adolescent engagement in mental health treatment? (4) How does the practitioner experience the impact of informed consent in building a relationship with the adolescent?

The interviews revealed that practitioners follow clinic policies of obtaining parental consent when providing mental health treatment to adolescents. Although some practitioners expressed how obtaining parental consent may be helpful, a significant number of the study participants noted that obtaining parental consent challenged their efforts to engage adolescents in clinical care. Relative to these challenges, a host of practice patterns emerged that affected how mental health care was delivered to adolescents. For instance, practitioners struggled with wanting to protect the privacy of adolescents while at the same time respecting parental
involvement (Hickey, 2007; Schachter et al., 2005; Tan et al., 2007). Confidentiality also led to concerns when establishing therapeutic-alliances, alliances which are premised upon issues of trust between practitioners and adolescents. The study participants also noted that adolescents did not participate and disengaged from therapy when parents became active participants in their care. In order to facilitate positive treatment outcomes and engagement in mental health care, practitioners, must therefore, encourage adolescents to actively participate in their own care. Furthermore, practitioners should equip themselves with knowledge of informed consent policies in order to support adolescent decision making and improve utilization of treatment (Adelman et al., 1984; Beeman & Scott, 1991; Taylor et al., 1985; Vukadinovich, 2004; Weithorn, 1985).

Practitioners who are unaware of the laws and regulations surrounding adolescent informed consent face particular challenges. As a result of their lack of knowledge, these practitioners obtained parental consent before engaging adolescents in therapy. This was a consistent barrier to the delivery of mental health services. As previously noted, regulations regarding informed consent are disseminated to licensed outpatient mental health clinics where they are interpreted and consequently shaped into ethical standards and clinic practices for practitioners. It is crucial for practitioners to know and understand the laws and regulations regarding informed consent in order to ensure that adolescents are ethically informed and can make decisions regarding their care (see Bello, 2010).

Programs that are youth driven and development focused need to provide services that are generally accessible and devoid of barriers that may discourage adolescents. In order to achieve adequate service delivery and programming for adolescents, their perspectives and experiences in clinical settings should be studied. Future research can demonstrate how adolescents perceive their mental health care and reveal any barriers to effective mental health
services. Practices that take adolescent decision-making capacities into account can provide favorable treatment results and build therapeutic alliances. Future studies can also analyze the influence parental involvement has on adolescent participation in their own mental health care and may serve to improve engagement and retention rates in mental health care settings.
Appendix A

Screening Guide

Thank you for agreeing to talk with me today. The purpose of this brief screening interview is to ascertain your experience with providing mental health treatment services to adolescents in outpatient mental health clinics. I will be asking questions with details in each question, which will provide me with information regarding your experience. Your identity and participation in this study will be confidential. Any potential identifying information that you discuss, like names, will be removed by me when the interview is transcribed. Thank you for your participation.

1. How did you become involved in the mental health treatment of adolescents?
   - Please indicate the length of time you have been working with this population.

2. How would you describe your current and past experience providing mental health treatment to adolescents?
   - What other client groups have you provided mental health services to? For example, young children, adults, and older adults?
   - Please compare the experience. How was it different? How was it similar?

3. How would you characterize your current work setting? Is it a clinic, program, agency, unit?
   - How is the setting licensed? For example, is it an Article 28 or Article 31 clinic? How is it staffed?
Appendix B

Socio-Demographic Questionnaire

Please Complete the Following:

1. Indicate the following by checking the appropriate box below.
   - Male
   - Female

2. What is your age? Place a check next to the age range below.
   - 25-35
   - 36-45
   - 46-55
   - Over 55

3. What is your race? Place a check next to the race you identify with.
   - White
   - Black/African American
   - Hispanic/Latino
   - Asian/Pacific Islander
   - Other

4. What is your current marital status? Place a check next to your status.
   - Single/Never Married
   - Married
   - Separated
   - Divorced
   - Widowed
   - Co-Habitating
5. Which best describes your level of licensure? Place a check next to your level.

   Licensed Master Social Worker ________
   Licensed Clinical Social Worker ________

6. Are you currently employed? Place a check next to your status.

   Employed ________
   Unemployed ________

7. What is your approximate yearly income? Place a check next to your income.

   Less than $20,000 ________
   $21,000-$35,000 ________
   $36,000-$50,000 ________
   $51,000-$65,000 ________
   Over $66,000 ________
Appendix C

Interview Guide

Thank you for agreeing to talk with me today. The purpose of this interview is to better understand your experience with obtaining parental consent for adolescent mental health services. I will be asking details in each question. The point is to try and create a thorough description of the different kinds of experiences you have with consent. Your identity and participation in this study will be confidential. Any potentially identifying information that you discuss, like names, will be removed by me when the interview is transcribed. Thank you for your participation.

1. What type of services does your clinic or agency provide?
   - What is the age range of your adolescent client population?

2. In your experience, who or what determines the policies regarding consent for adolescent treatment?
   - As a practitioner, what are your responsibilities regarding informed consent?

3. What is your understanding of New York State Mental Health Law regarding informed consent for adolescents?

4. How is an adolescent admitted into your program or clinic for mental health treatment?
   - Do you obtain parental consent before the onset of treatment?

5. How does informed consent affect the delivery of treatment to the adolescent?
   - How does the delivery of services change for an adolescent who has self-consented for treatment in comparison to the adolescent whose parent has consented for mental health treatment?
   - Are you engaging in the treatment process differently? Please explain.
   - Does the adolescent respond differently to treatment when the parent renders consent or when he or she has self-consented?

6. Do parents often contact you wanting information about their children? If so, how do you manage the parent’s inquiry?

7. How does informed consent either by parent or adolescent influence the therapeutic relationship?
   - Are you able to establish trust or rapport? Please describe.
   - Is there a difference in resistance to treatment? If so, please illustrate.

8. How does informed consent either by parent or adolescent impact or affect utilization of therapy?
   - Do the adolescents remain in treatment for an extended amount of time? If so, please describe.
- Do adolescents drop out during the course of treatment after their parents have signed consent? If so, do they return to services? Please describe. Compare this to an adolescent who is not under a parental consent decree.

9. In your experience, at what age do adolescents have the capacity to determine their own mental health treatment?
   - What are the factors that determine whether an adolescent has the capacity to consent for their own mental health treatment? Please describe.
   - When assessing capacity for adolescent consent for mental health treatment, are there factors that may interfere with this process? If so, what are they? Please describe.
   - Are their ethical considerations regarding an adolescent’s capacity to consent for mental health treatment? If so, please describe.
   - In your experience, do adolescents understand the risks and benefits of mental health treatment? Please provide illustrations.
Appendix D

Participant Consent Form

CITY UNIVERSITY OF NEW YORK

Silberman School of Social Work at Hunter College
Doctorate Program in Social Welfare
PARTICIPANT CONSENT FORM

Project Title:
Adolescent Informed Consent: Treatment Practices and Consequences

Principal Investigator:
Blanca I. Santana, LCSWR, Doctoral Candidate
PhD Program in Social Welfare
Silberman School of Social Work at Hunter College
2180 Third Avenue, 6th Floor
New York, NY, 10035
212-453-4521

Faculty Advisor:
Manny J. González, PhD, Professor and Faculty Advisor
PhD Program in Social Welfare
Silberman School of Social Work at Hunter College
2180 Third Avenue, 6th Floor
New York, NY, 10035
212-396-7554

Site Where Study Is to Be Conducted:
Silberman School of Social Work at Hunter College
2180 Third Avenue, New York, New York 10035

Introduction/Purpose: You are invited to participate in a research study. The study is conducted under the direction of Blanca I. Santana, LCSWR Doctoral Candidate at the Silberman School of Social Work at Hunter College. The purpose of this research study is to understand how the phenomenon of consent is experienced by providers and whether this creates a barrier to receiving adolescent mental health treatment. Examining these relationships and experiences affords the opportunity to explore factors such as provider obligations, what and who informs policies around consent, and the adolescent’s response to the treatment process.
Procedures: Each participant will consent by voluntarily signing this letter to participate in one interview with a series of questions. The questions will ask participants about the nature of their experience in mental health settings, their experience working with adolescents and their experience with obtaining informed consent. The time commitment of each participant is expected to be two to three hours. Each session will take place at the Silberman School of Social Work at Hunter College located at 2180 Third Avenue, New York, NY 10035.

Possible Discomfort and Risks: Your participation in this study may involve breach of confidentiality. To minimize these risks or any embarrassment, all participants will be informed about the voluntary nature of participation in the study and the manner in which privacy will be assured.

Benefits: There are no direct benefits. However, participating in the study may increase general awareness of adolescent treatment practices and consequences in mental health.

Alternatives: Not applicable.

Voluntary Participation: Your participation in this study is voluntary, and you may decide not to participate without prejudice, penalty, or loss of benefits to which you are otherwise entitled. If you decide to leave the study, please contact the principal investigator, Blanca I. Santana, LCSWR, to inform her of your decision.

Financial Considerations: Participation in this study will involve no cost to the subjects and you will not receive any compensation for participating.

Privacy and Confidentiality: Once consent is obtained, the data obtained from you will be collected via writing. The collected data will be collected and accessible to the principal investigator, Blanca I. Santana, LCSWR, to protect against breach of confidentiality. As the researcher, I will protect your confidentiality and privacy by coding and encrypting any identifying information such as names using symbols or numbers. Confidentiality will be achieved by storing the data in a secure, locked cabinet. Once all data is collected and analyzed, the data will retained in a locked and secure cabinet for a period of at least three years after the research has been discontinued. During this period, only I, as the principle investigator, will have access to the data. After the three years, the data will be destroyed. Consent forms with identifiable information will be maintained separately from your coded data and also destroyed once the data is collected and analyzed.

Contact Questions/Persons: If you have any questions about the research now or in the future, you should contact the principal investigator, Blanca I. Santana, LCSWR, at 212-453-4521 or at bsantan@hunter.cuny.edu. If you have any questions concerning your rights as a participant in this study, you may contact Sarah Leon at 212-650-3053 or bleon@hunter.cuny.edu.
**Statement of Consent:**

“I have read the above description of this research and I understand it. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions that I may have will also be answered by the principal investigator of the research study. I voluntary agree to participate in this study.

By signing this form, I have not waived any of my legal rights to which I would otherwise be entitled.

I will be given a copy of this statement.”

_________________________  _____________________________  __________________________
Printed Name of Subject Signature of Subject Date Signed

_________________________  _____________________________  __________________________
Printed Name of Person Explaining Consent Form Signature of Person Explaining Consent Form Date Signed

_________________________  _____________________________  __________________________
Printed Name of Investigator Signature of Investigator Date Signed

CUNY UI - Institutional Review Board
Approval Date: April 07, 2014
Expiration Date: April 06, 2015
Coordinator Initials: SL

**CUNY University Integrated IRB Protocol: 313236**

**CUNY University Integrated IRB Protocol: 313236 Approved: 04/07/2014 Expires: 04/06/2015**
Appendix E

Approval Letter

Human Research Protections Program
Hunter College (CUNY) HRPP Office

DATE: August 27, 2013

TO: Blanca Santana

FROM: Hunter College (CUNY) HRPP Office

PROJECT TITLE: [313236-3] Mental Health Practitioner's Perception of Informed Consent with Adolescents

SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVED

APPROVAL DATE: August 27, 2013

EXPIRATION DATE: April 1, 2014

RISK LEVEL: Minimal Risk

REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # 6 & 7

Thank you for your submission of Amendment/Modification materials for this project. The University Integrated IRB has APPROVED:

1) Revised interview guide.
2) Addition of screening guide.
3) Addition of "Sociodemographic questionnaire" to be administered before the approved interview.
4) Addition of an audio consent form for permission to record interview.
5) Change in title to, "Mental Health Practitioner's Perceptions of Informed Consent with Adolescents".

This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

Please remember that informed consent is a process beginning with a description of the project and assurance of the participant's understanding, followed by a signed consent form(s). Informed consent must continue throughout the project via a dialogue between the researcher and research participant.

Federal regulations require that each participant receives a copy of the consent document.

The University Integrated IRB has determined that a waiver of documentation of consent has been approved for the screening portion of this research, under 45 CFR 46.117.
Please note that any modifications/changes to the approved materials must be approved by this IRB prior to implementation. Please use the appropriate modification submission form for this request.

All UNANTICIPATED PROBLEMS (UPS) involving risks to subjects or others, NON-COMPLIANCE issues, and SUBJECT COMPLAINTS must be reported promptly to this office. All sponsor reporting requirements must also be followed. Please use the appropriate submission form for this report.

This research must receive continuing review and final IRB approval before the expiration date of April 1, 2014. Your documentation for continuing review must be received with sufficient time for the IRB
References


Watson, A. C., Kelly, B. L., & Vidalon, T. M. (2009). Examining the meaning attached to mental illness and mental health services among justice system-involved youth and their parents. *Qualitative Health Research, 19*(8), 1087-1099.


